

Reg. Dist. No.

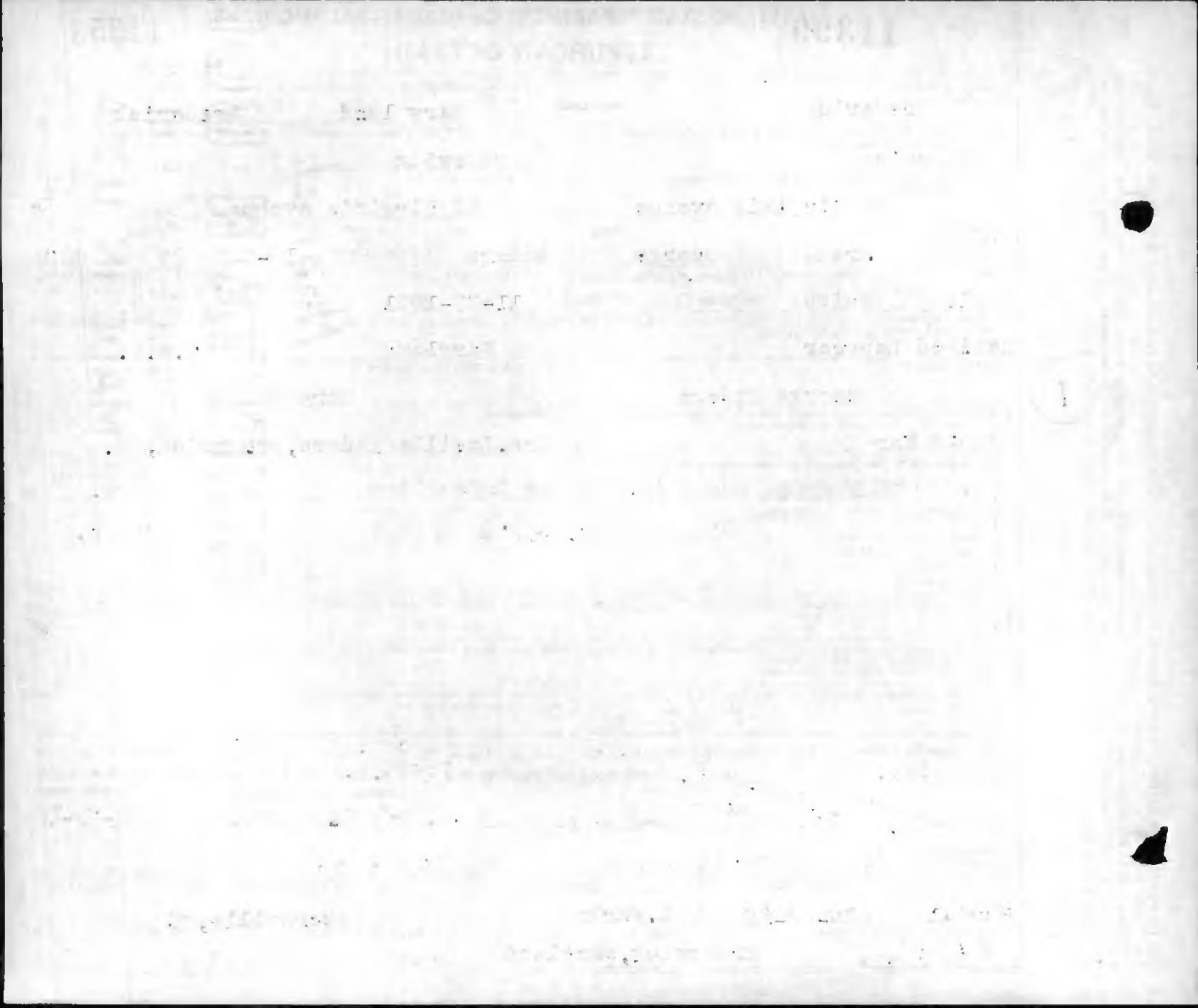
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Frederick			MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 28 Virginia Avenue			d. STREET ADDRESS 28 Virginia Avenue			b. COUNTY Frederick				
3. NAME OF DECEASED (Type or print) Frank George Anders			First Frank	Middle George	Last Anders	4. DATE OF DEATH 10-25-1960	Month 10	Day 25	Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11-27-1901	9. AGE (In years lost birthday) 58	IF UNDER 1 YEAR Months 58	IF UNDER 24 HRS Days 58	Year Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Anders					14. MOTHER'S MAIDEN NAME Mary ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War I			16. SOCIAL SECURITY NO.			INFORMANT Mrs. Lucille Anders, Brunswick, Md.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute Myocardiac Infarction INTERVAL BETWEEN ONSET AND DEATH 2 hr.										
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 (b) Coronary Thrombosis 3 yrs.										
DUE TO DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D. 15 So. Maryland Ave.		(County) 10-27-60	(State)
21. I certify that I attended the deceased from Aug. 28 , 19 60 , to Oct. 25 , 19 60 , that I last saw the deceased alive on Oct. 25 , 19 60 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.										
ADDRESS (Street, city or town, state) Petersville, Md.										DATE SIGNED 10-27-60
ACTUAL SIGNATURE 										
PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-60		22c. NAME OF CEMETERY OR CREMATORIAL St. Marks			22d. LOCATION (City, town, or county) Petersville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Brunswick, Maryland			24a. REC'D BY REGISTRAR OCT 31 '60		24b. REGISTRAR'S SIGNATURE 			

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 FOR STATE
HEALTH DEPT.

M

1137 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY ?	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 1011-1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Edgar Middle Baker	
4. DATE OF DEATH October 2 1960		5. SEX Male	
6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	
9. AGE (in years last birthday) 25 yr.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Was a migrant worker to get any data	
11. KIND OF BUSINESS OR INDUSTRY Except above		12. BIRTHPLACE (State or foreign country) ?	
13. FATHER'S NAME Except above		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 824X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. TIME OF INJURY Month, Day, Year AM 30 9/5 1960		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Thrown from a truck hauling corn	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 67&340 20e. (City or town) Nr Wayverton Frederick Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED October 4, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-9-60 22c. NAME OF CEMETERY OR CREMATORIUM FAIRVIEW	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks III		ADDRESS Frederick-Md. 24a. REC'D BY REGISTRAR DATE OCT 11 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11355

11407

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Frederick				Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	
CULLEN		549 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Victor Cullen State Hospital		Baltimore City			
d. STREET ADDRESS		1031 West Baltimore			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Paul		P.		Buckworth	Month 10 Day 15 Year 1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 56 yrs.
m		w		10-11-1904	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk		Liquor Stores		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Arch Buckworth		Minnie Buchelle		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		217-07-5748		Record of Victor Cullen State Hosp.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Palmonary Tuberculosis - 002			
002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 years.			
DUE TO (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____ 4/15 1959 to 10/15 1960, that (I) (we) last saw the deceased alive on 10/15 1960, and that death occurred on 4/15 1960, from the causes and on the date stated above.					
22a. SIGNATURE		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/15/60	
Michael G. Zavis M.D.					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
Michael G. Zavis		Cullen, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-19-60		23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery	
23d. LOCATION (City, town, or county) Chesapeake City, Md		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR OCT 19 '60	
Wm. Cook, Inc., 1217 St. Paul Street				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11356

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 16.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 107 Stekett Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Shaeffer Virginia Budd		First	Middle
		Last	4. DATE OF DEATH October 16 1960
5. SEX female		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Same	
10c. BIRTHPLACE (State or foreign country) U.S.A.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Kraece Alvin Budd	
14. MOTHER'S MAIDEN NAME JANICE Virginia Slattery		Address As Item #2	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Erythromelastosis foetalis	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 770.		DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subarachnoid hemorrhage		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick (County) Maryland (State)	
21. I certify that (I) (this hospital) attended the deceased from 16 Oct 1960 to 16 Oct 1960 , that (I) (we) last saw the deceased alive on 16 Oct 1960 , and that death occurred at 16 Oct 1960 from the causes and on the date stated above.			
22a. SIGNATURE A. M. Powell Jr.		22b. DATE SIGNED 17 Oct 60	
22c. PHYSICIAN'S NAME (Type) A. M. Powell Jr.		22d. ADDRESS Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 18, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION (City, town, or county) Frederick, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE OCT 19 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

11/29/67 electrical controls

11/29/67 electrical controls

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

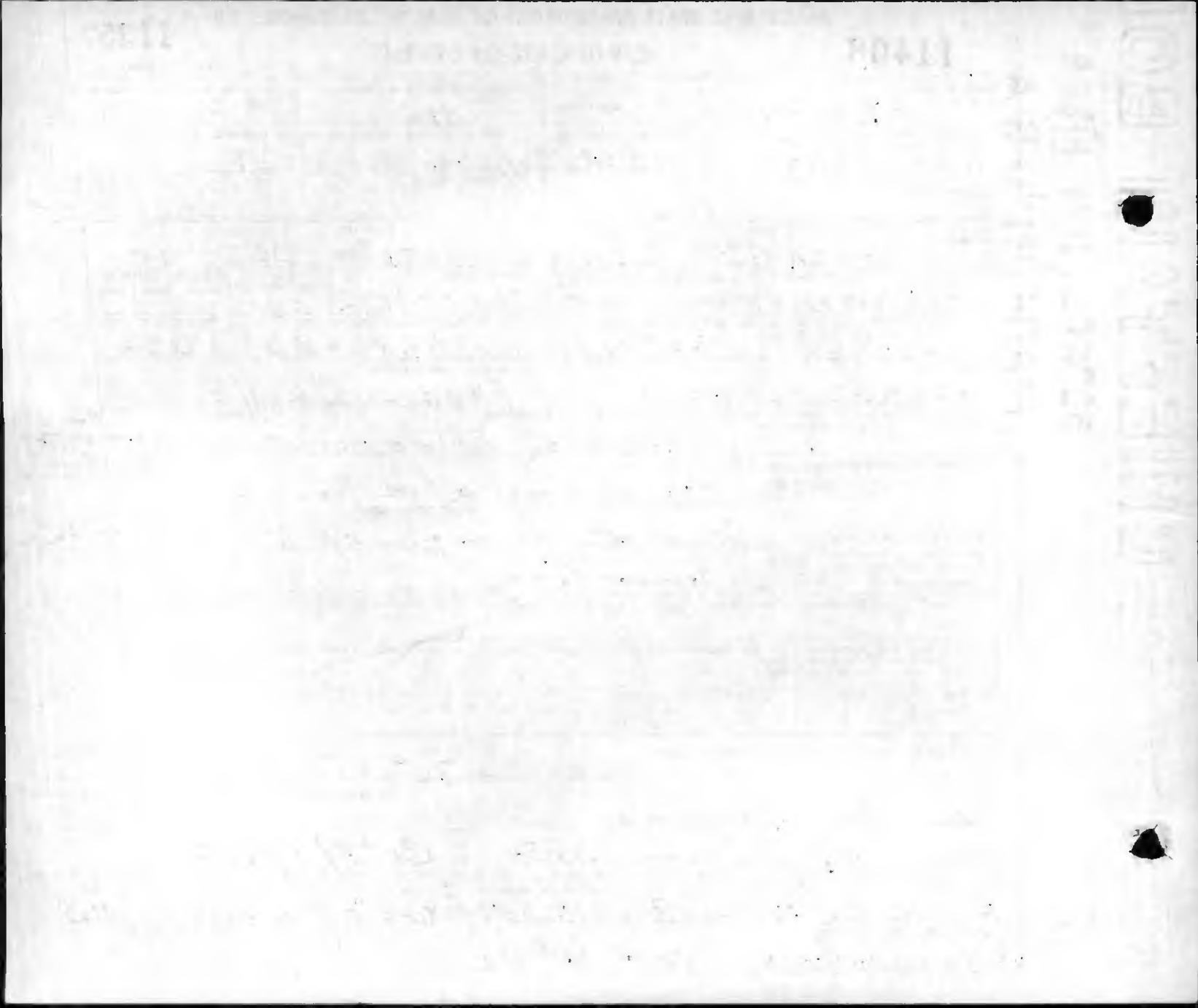
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Medical Certification

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11357			
CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY		FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE MD b. COUNTY FREDERICK					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		NEW MARKET				c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						12 YRS		d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First GEORGE		Middle EZRA		Last BURKETT		4. DATE OF DEATH		Month OCT	Day 18	Year 1960	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)		IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		JAN 6-1892		68 yrs.		Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
LABORER		FACTORY		MARYLAND		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address									
GEORGE BURKETT		FAUNIE CLINE		MD									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
(If yes, give war or dates of service)		217-28-5358		ELIZA R. BURKETT NEW MARKET		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carcinoma body someres					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)		Metastasis liver lungs & brain		5 months							
		DUE TO (c)		Inscinting									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		157		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)		Metastasis liver lungs & brain									
		DUE TO (c)		Inscinting									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY		Month	Day	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
				Hour	o. m.	19			While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 710 M, from the causes and on the date stated above.		ACTUAL SIGNATURE		B. D. Thomas		M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED			
PHYSICIAN'S NAME (Type)		B. D. Thomas, MD		Oct 19, 1960									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)				(State)			
BURIAL		OCT 20 1960		FREDERICK MEMORIAL		FREDERICK		MD					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Lucian K. Falcone		New Market MD		OCT 24 '60		Arthur S. Kline							
VS A15 (4)													
15M 9/58													



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Part B/2 10-7-60 et

11376

11358

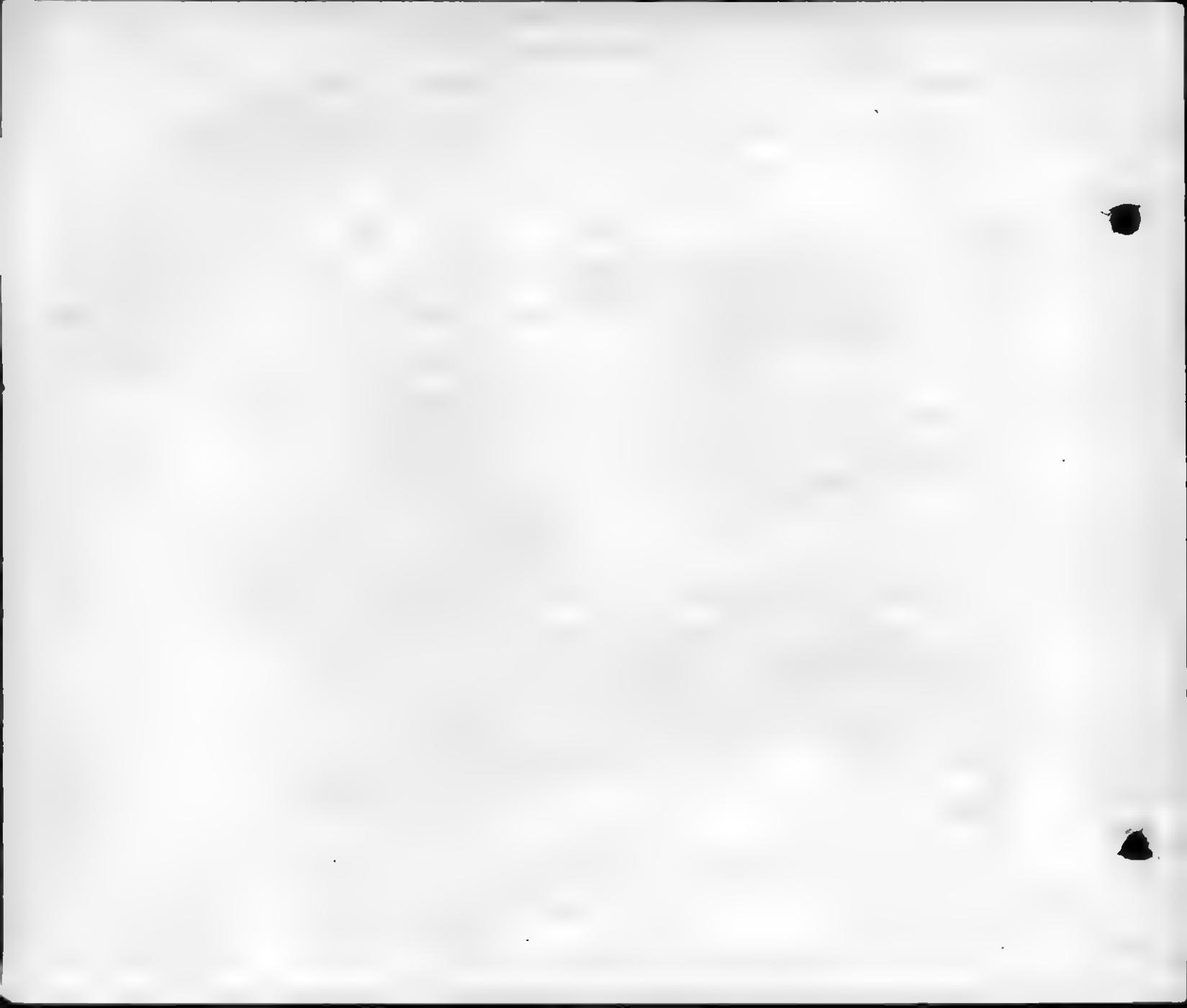
CERTIFICATE OF DEATH

Reg. Dist. No.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in permanent within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 971 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 509 S. Market St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick county chronic Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Rudolph	Middle chabacky	Last chabacky	4. DATE OF DEATH 10 2 1960	Month 10	Day 2	Year 1960
5. SEX M	6. COLOR OR RACE W	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. B. DATE OF BIRTH May 18 1882	8. AGE (In years last birthday) 78 yrs.	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Europe		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ignatius chabacky		14. MOTHER'S MAIDEN NAME Josefa		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None 17. INFORMANT Address mc. Angelo Cramer 112 N. Market St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 5 yrs.					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr 1, 1960 to Oct 1, 1960 , that I last saw the deceased alive on Oct 1, 1960 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. 9 N. Market St. Frederick, Md.		DATE SIGNED Oct 4, 1960	
ACTUAL SIGNATURE H. F. Kline		PHYSICIAN'S NAME (Type) H. F. KLINE MD		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-60	
22c. NAME OF CEMETERY OR CREMATORIUM Shaw's Chapel		22d. LOCATION (City, town, or county) Frederick, Md.		22e. DATE Oct 4, 1960		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Ellis Jr. 2100 Euston Place		ADDRESS 2100 Euston Place		24a. REC'D BY REGISTRAR DATE Oct 4 '60		24b. REGISTRAR'S SIGNATURE John S. Thorne	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

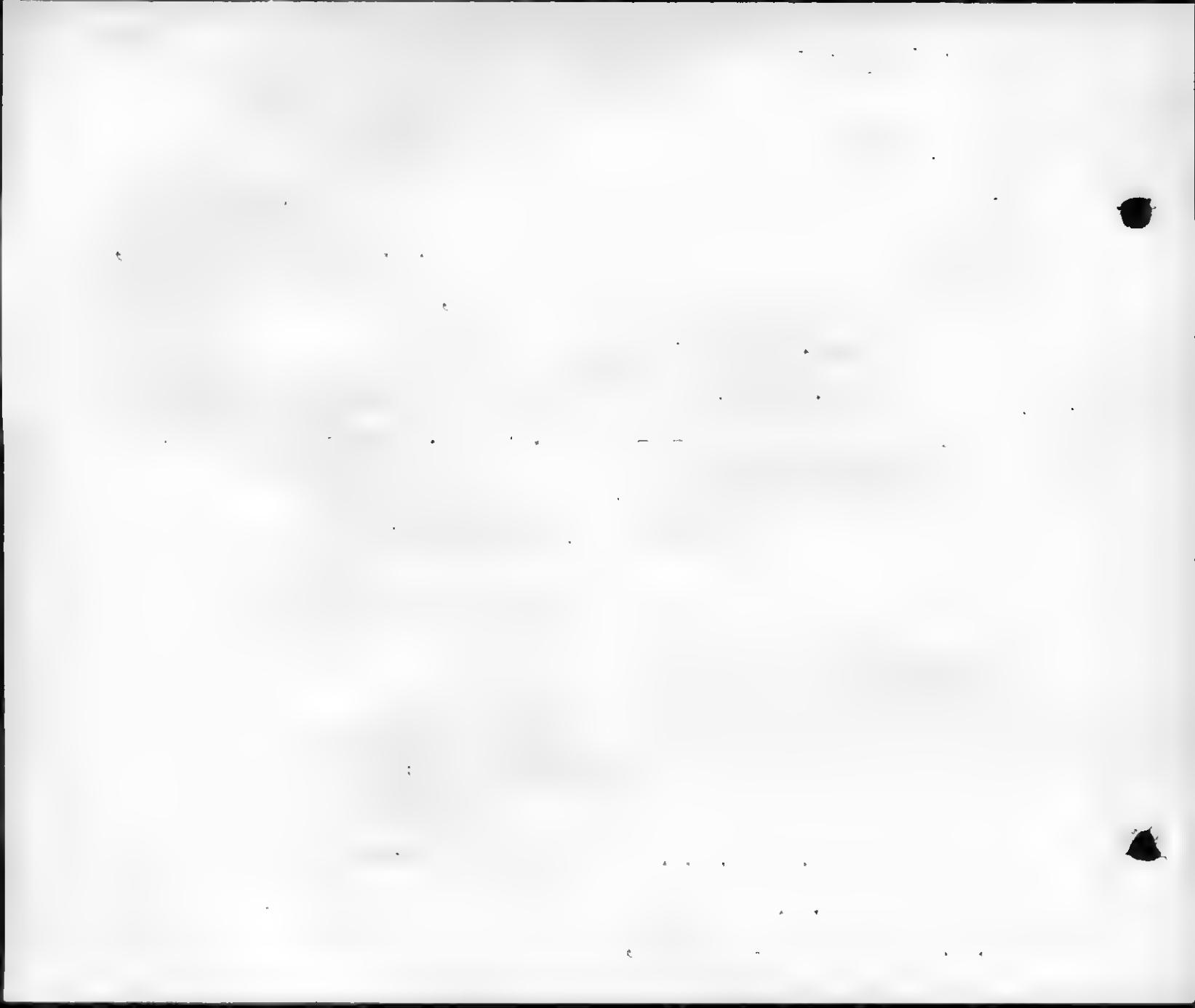
11377

11359

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in, the funeral director, page 3 should be detached as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Frederick			MARYLAND			2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN lb Years			b. COUNTY Frederick					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 327 North Market Street						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					
3. NAME OF DECEASED (Type or print) MICHAEL			First MICHAEL	Middle JOSEPH	Last CROGHAN, SR.	4. DATE OF DEATH October 23, 1988	Month October	Day 23	Year 1988	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1988	9. AGE (In years last birthday) 72	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Owner & Mgm.			10b. KIND OF BUSINESS OR INDUSTRY Hotel			11. BIRTHPLACE (State or foreign country) Ireland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John J. Croghan			14. MOTHER'S MAIDEN NAME Sarah Fahy								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 218-30-7891			17. INFORMANT Mrs. Hilda B. Croghan-Same as Item #2			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 1-2 hr. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerotic Heart disease 4-5 yrs DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 17 1960 to Oct 23 1960 that (I) (we) last saw the deceased alive on Oct 23 1960 , and that death occurred at 2:00 PM from the causes and on the date stated above 22a. SIGNATURE Henry V. Chase											
22c. PHYSICIAN'S NAME (Type) Henry V. Chase, M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22d. DATE SIGNED 10/24/60						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Oct. 26, 1960 23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery 23d. LOCATION (City, town, or county) Frederick, Maryland (State)											
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland						ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 26 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be retained by the hospital or attending physician. Page 1 and 2 may be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11360

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick		MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Frederick Memorial Hosp.			
1319 West Patrick St.			
3. NAME OF DECEASED (Type or print)		First	Middle
William Ronald		Delauter	Last
4. DATE OF DEATH		Month	Day
		October	20
		Year	1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> October 20, 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country)	
		Maryland	
12. CITIZEN OF WHAT COUNTRY?		u.s.a.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Roy & Leslie Delauter		Arline Frances Hildebrand	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Address	
Mother, 319 W. Patrick, St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
762.5		7 days atelectasis	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b)		Prematurity (28 weeks)	
DUE TO			
(c)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 20, 1960, to Oct. 20, 1960, that (I) (we) last saw the deceased alive on Oct. 20, 1960, and that death occurred at 7:55 A.M. from the causes and on the date stated above			
22a. SIGNATURE		22b. DATE SIGNED	
Bernard O. Thomas			
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
Dr. Bernard O. Thomas		22d. ADDRESS	
Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
burial		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	
23d. LOCATION (City, town, or county) (State)		Frederick, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR DATE	
Gladhill Company, Middletown, Md.		25b. REGISTRAR'S SIGNATURE Clyburn S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11361

11370

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson	
3. NAME OF DECEASED (Type or print) JULIA		4. DATE OF DEATH October 20, 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH January 4, 1868	
9. AGE (In years last birthday) 92		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Virginia		14. MOTHER'S MAIDEN NAME Olivia Fout	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. William D. Royer—Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (c) <i>412</i> <i>Chronic Myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3yrs</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>Seizure</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick (County) Maryland (State)	
21. I certify that I attended the deceased from Oct 18 , 1960, to Oct 18 , 1960, that I last saw the deceased alive on Oct 18 , 1960, and that death occurred at 7:30 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7 North Market Street Frederick DATE SIGNED 10/20/1960	
ACTUAL SIGNATURE <i>H. F. Kline M.D.</i>			
PHYSICIAN'S NAME (Type) H. F. Kline, M.D.		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/1960	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. E. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 24 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. This page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												11362					
CERTIFICATE OF DEATH												Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Frederick				MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland				b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,				c. LENGTH OF STAY IN lb Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,				d. STREET ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Dolor				First		Middle		Last		4. DATE OF DEATH October 26,		Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan. 9, 1900		9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Emmitsburg, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joseph E. Eyler				14. MOTHER'S MAIDEN NAME Jennie Tressler													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO 216-14-6123				INFORMANT		Address Mrs. Roland Sanders, Emmitsburg, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 452.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Arteriosclerotic Cardiovascular disease 10 yrs.												INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Oct 26 , 1960, to Oct 26 , 1960, that I last saw the deceased alive on Oct 26 , 1960, and that death occurred at 7 P.M. from the causes and on the date stated above.												ADDRESS (Street, city or town, state) 10/28/60					
ACTUAL SIGNATURE George L. Morningstar M.D.																	
PHYSICIAN'S NAME (Type) GEORGE L. MORNINGSTAR																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 30, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Mt. View Cemetery				22d. LOCATION (City, town, or county) Emmitsburg, Frederick Co. Md.				(State)					
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson				ADDRESS Emmitsburg, Md.				24a. REC'D BY REGISTRAR Oct 31 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan							
C. E. Wilson																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cancellation, or removal, and in any event, within 72 hours after death.

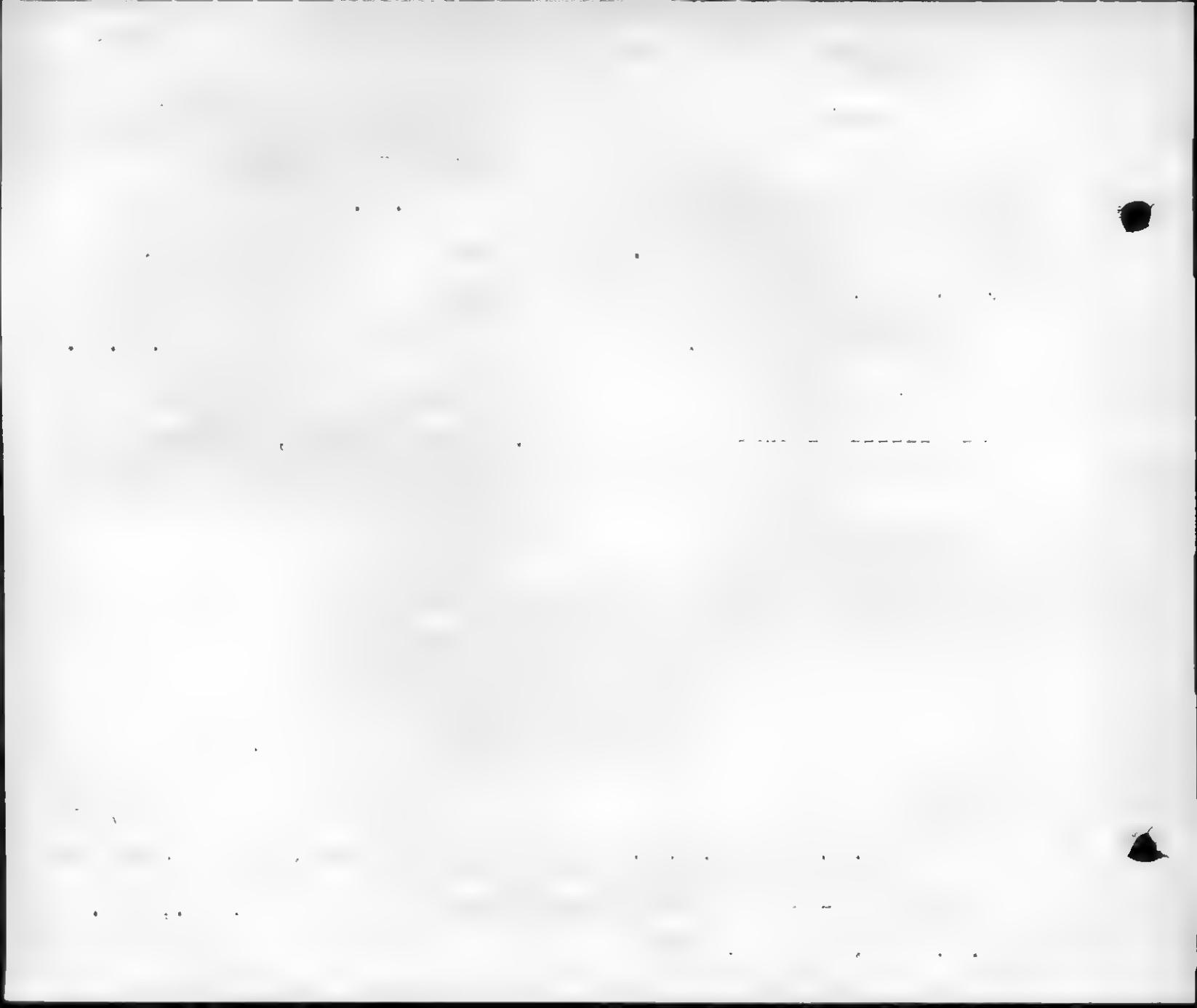
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11363

11380

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Woodbine	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS R. D.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) AMY		First N.	Middle FLEMING	Last 18	4. DATE OF DEATH October
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 11, 1995	9. AGE (In years last birthday) 05 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Jesse Leatherwood		14. MOTHER'S MAIDEN NAME Minnie Harrison		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Albert Pickett, Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) ----- (c)		<i>Caeruleoma of Pancreas</i>		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 14, 1960 to October 3, 1960 , that (I) (we) last saw the deceased alive on 10/3/1960 and that death occurred at M. from the causes and on the date stated above.					
22a. SIGNATURE Richard C. Reynolds		M. D.		22b. DATE SIGNED 10/4/60	
22c. PHYSICIAN'S NAME (Type) R. C. Reynolds, M. D.		22d. ADDRESS East Church Street, Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-6-1960		23c. NAME OF CEMETERY OR CREMATORIAL Morgan Chapel Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 7 '60	
				25b. REGISTRAR'S SIGNATURE Charles L. Finch	



1
11381
11364
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4
may be referred to by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 12 Da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Thurmont Rural	
3. NAME OF DECEASED (Type or print) MARTIN		First LESTER	Middle FRESHMAN
4. DATE OF DEATH Oct. 5. 1960		Month Oct.	Day 5
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sept. 3.1906
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Filling Sta.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Martin H. Freshman	
14. MOTHER'S MAIDEN NAME Emma Brice		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 220-05-6900		17. INFORMANT Mrs Glenna Eyler. Thurmont. MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 6 Mos.	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Part II	
22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 4. 1960</u> to <u>Oct. 5. 1960</u> that (I) (we) last saw the deceased alive on <u>Oct. 5. 1960</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.		22b. DATE SIGNED 1960	
22c. PHYSICIAN'S NAME (Type) L.R. Schoolman		22d. ADDRESS 810 Toll House Ave. Frederick. MD	
23a. BURIAL, CREMATION Burial		23b. DATE THEREOF Oct. 8.1960	
23c. NAME OF CEMETERY OR CREMATORIAL United Brethren Cem		23d. LOCATION (City, town, or county) Thurmont Fred. Co MD	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		25a. ADDRESS Thurmont. MD	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. REC'D BY REGISTRAR DATE OCT 10 '60	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PHM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11365

11409		Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Frederick- Route 2		c. LENGTH OF STAY IN lb 25 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural-Frederick- Route 2	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Henry Goodsell		4. DATE OF DEATH Month October Day 15 Year 19 60	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 7-1896	
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Used auto dealer		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Goodsell		14. MOTHER'S MAIDEN NAME Florence Ausherman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO WWar 1	
17. INFORMANT Not available		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		INTERVAL BETWEEN ONSET AND DEATH 2 hour	
(b) Pulmonary T.B.		5 yrs. plus	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas-Sr.		DATE SIGNED 10-15-1960	
22a. DATE OF REMOVAL (Specify) Burial		22b. DATE THEREOF 10-18-1960	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick- Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Whaley, Frederick Md.</i>		24a. ADDRESS 24b. REC'D BY REGISTRAR DATE OCT 20 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be read by the hospital or attending physician.

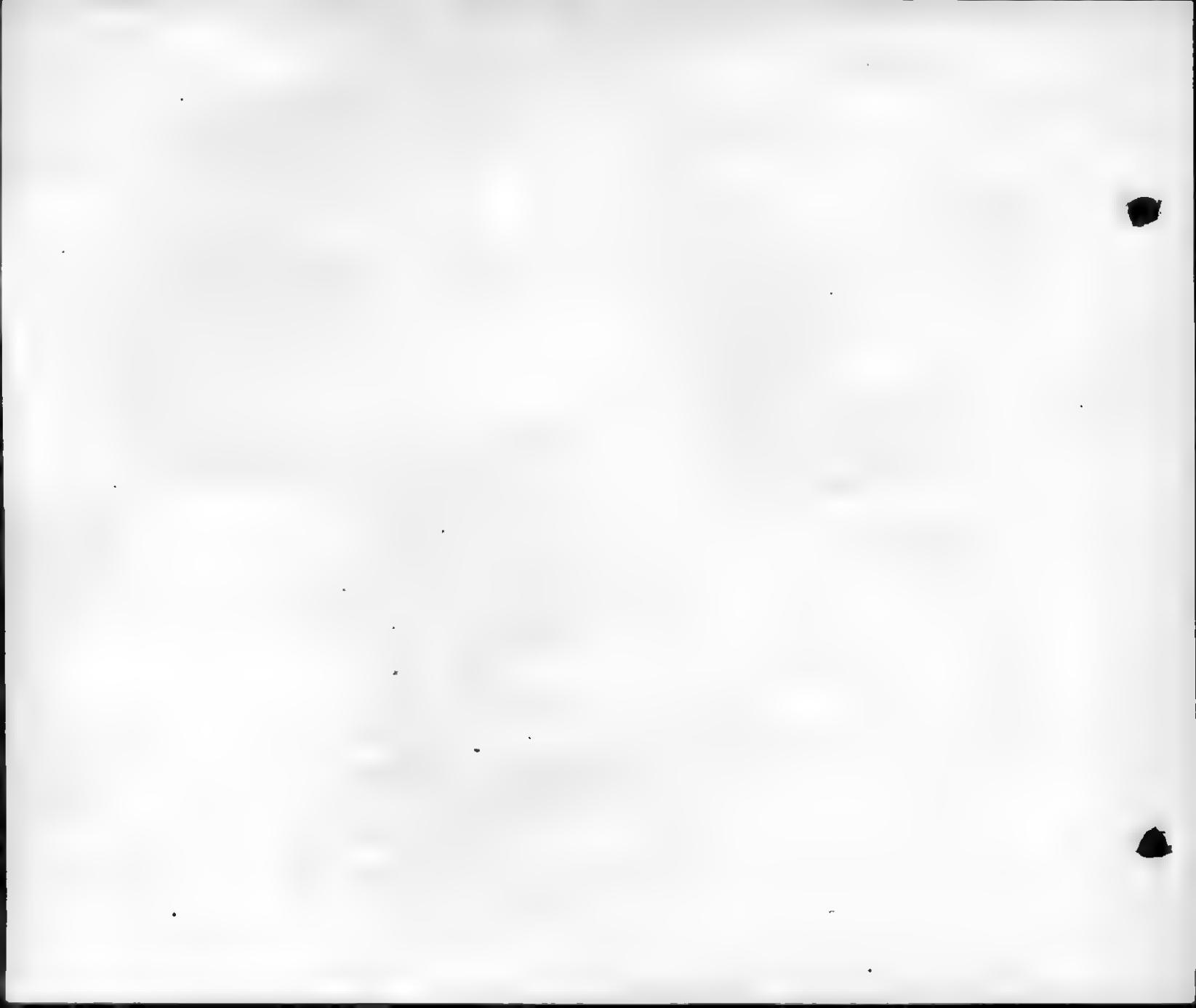
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11366

11410		Item 2		10-11-60 at	
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE		3. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frederick		Maryland		53 days	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
Cullen		X Cullen		No St. or number	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH	
Victor Cullen State Hospital				10 2 19 60	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
M -		W.		8. DATE OF BIRTH	
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Laboratory technician		Hospital		Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		Louis Gray		Bertha Elliott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service)		217-32-5841		Record of Victor Cullen Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)					
002 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.					
DUE TO (b)					
DUE TO (c)					
Pulmonary Emphysema - 527					
Pulmonary Tuberculosis - 002					
Bronchiectasis - 526					
INTERVAL BETWEEN ONSET AND DEATH 1 year					
20 yrs					
15 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
Hypertension heart disease - 442					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
19 60		8/10 1960		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/10 1960 to 10/2 1960, that (I) (we) last saw the deceased alive on 10/1 1960, and that death occurred at 7:30 AM from the causes and on the date stated above.					
22a. SIGNATURE		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGN 10/2/60	
Michael G. Zavis		22d. ADDRESS		Cullen, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-5-60		23c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR	
Raymond Cullen		Thurmont, Md.		DATE OCT 4 '60	
15M 9/59				25b. REGISTRAR'S SIGNATURE	
Raymond Cullen				Cuthbert S. Knapp	



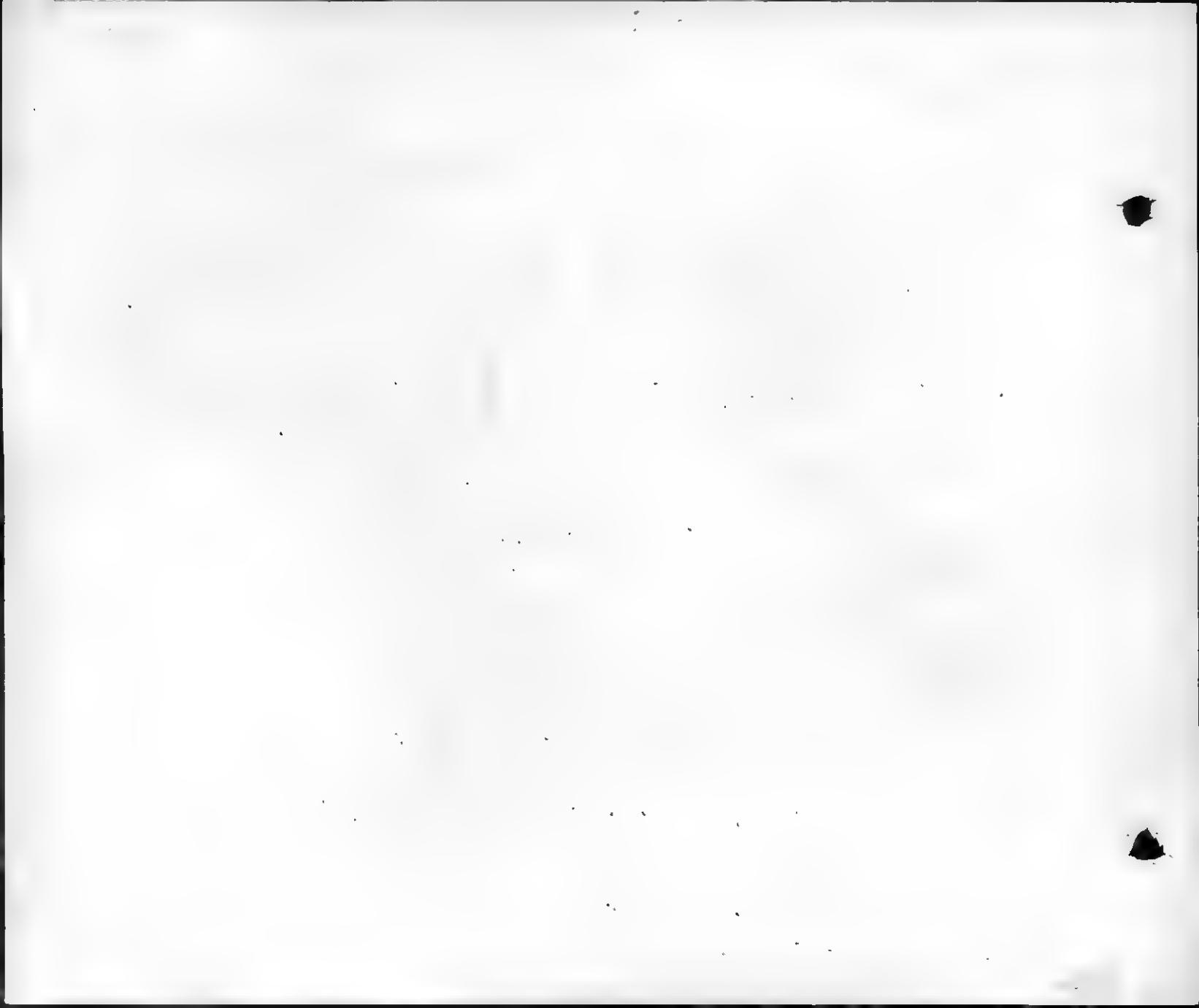
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11367

Reg. Dist. No.

1 M X I J		11411		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
		a. COUNTY	MARYLAND	a. STATE	MD
3. PLACE OF DEATH		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
a. COUNTY		I JAMSVILLE		X I JAMSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
CAROLYN		SUE	Hamilton	1. Oct. 23	Month Day Year
S. SEX		6. COLOR OR RACE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9 AGE (In years lost birthday) yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
FEMALE		WHITE		Oct 23 1960	Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		JAMES HAMILTON		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		14. MOTHER'S MAIDEN NAME	
		INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		762.5			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cerebral anoxia			
DUE TO (b)		Prematurity (7-20-66.)			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 23, 1960, to Oct 23, 1960, that I lost sight of the deceased alive on Oct 23, 1960, and that death occurred at 10 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE		DATE SIGNED			
PHYSICIAN'S NAME (Type)		10/23/66			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
BURIAL		Oct 23, 1960		I JAMSVILLE CEM	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Lucian K. Falconer New Market				24b. REGISTRAR'S SIGNATURE	
VS AII (4)		DANOV 2 '60		Cynthia L. Thomas	
15M 9/58					



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11368

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Lee Place			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First John	Middle H.	Last Horine	4. DATE OF DEATH October 20 1960	Month Day Year
5. SEX male	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/1877	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bus driver			10b. KIND OF BUSINESS OR INDUSTRY school bus		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Joshua Horine			14. MOTHER'S MAIDEN NAME Alice Schildknecht		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Galen Smith, 613 Wilson Place, Frederick, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uterine					
DUE TO Chronic Pyelonephritis					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aneurysm of abdominal Aorta					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 15 1960 to Oct 20 1960 , that (I) (we) last saw the deceased alive on Oct 18 1960 , and that death occurred at 5 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Dr. L. R. Schoolman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/20/60	
22c. PHYSICIAN'S NAME (Type) Dr. L. R. Schoolman		22d. ADDRESS Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/23/1960		23c. NAME OF CEMETERY OR CREMATORIAL U.R. Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		23d. LOCATION (City, town, or county) (State) Myersville, Md.			
ADDRESS		25a. REC'D BY REGISTRAR OCT 24 '60			
DATE		25b. REGISTRAR'S SIGNATURE Albert L. Trahan			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be read by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11369

11412		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		c. LENGTH OF STAY IN lb Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Convalescent & Rest Home		d. STREET ADDRESS Near Jefferson	
3. NAME OF DECEASED (Type or print)		First LEROY	Middle CULLER	Last HORINE	4. DATE OF DEATH Month October Day 27, 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1875	
9. AGE (In years last birthday) 85 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? USA		12. ADDRESS	
13. FATHER'S NAME Carlton Randolph Horine		14. MOTHER'S MAIDEN NAME America Eliza Culler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT None		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 794X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-7 1958 to 10-27-1960 that (I) (we) last saw the deceased alive on 10-27 1960, and that death occurred at 2:00 P.M. from the causes and on the date stated above.		22a. SIGNATURE Rex R. Martin		22b. DATE SIGNED 10/28/1960	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS North Market Street, Frederick, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF Oct. 30, 1960		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery		23d. LOCATION (City, town, or county) Jefferson, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 1 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus		26. DATE		27. ADDRESS	



11370

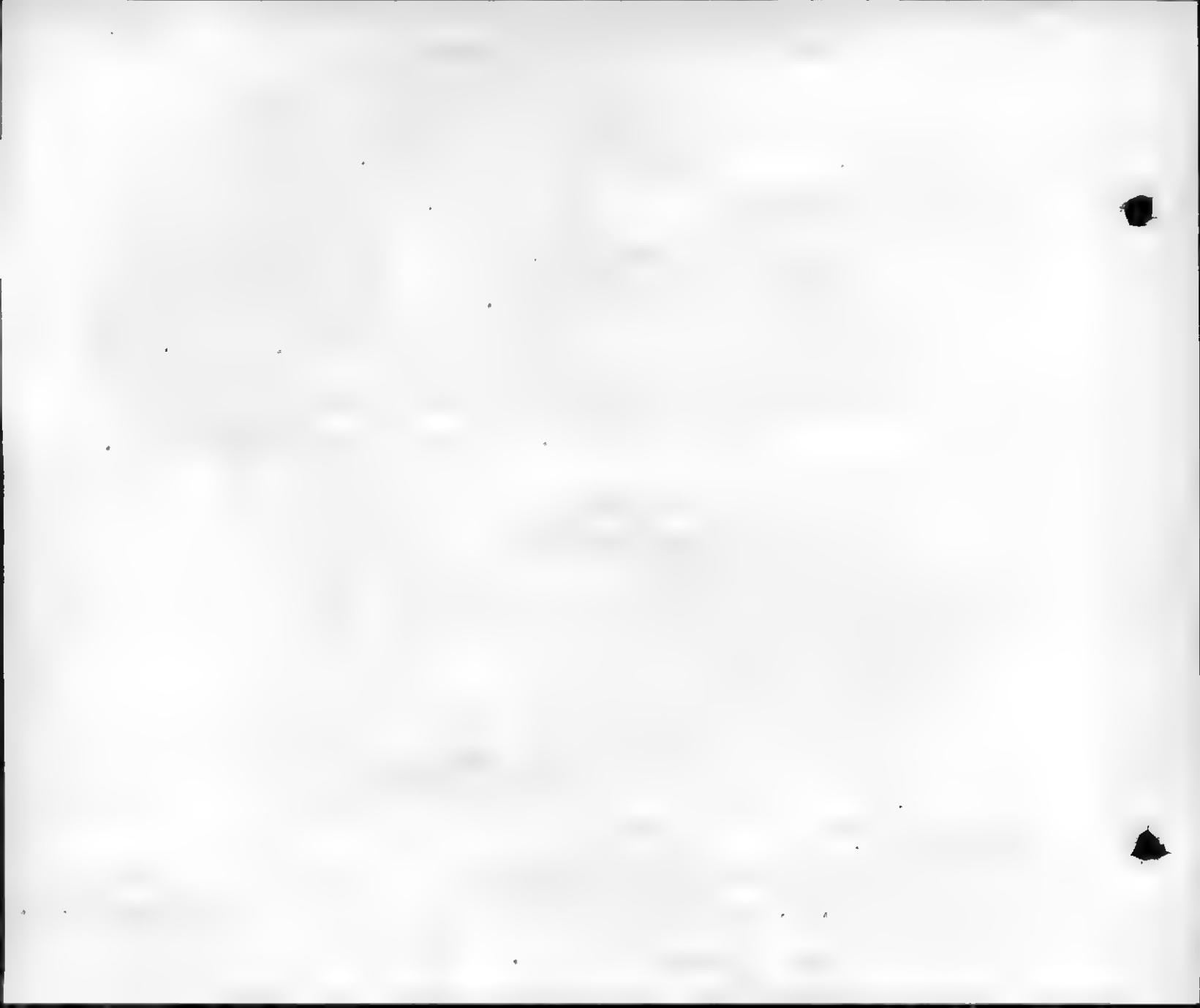
TO HOSPITAL by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,		c. LENGTH OF STAY IN 1b 35 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100 East Main Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,		f. STREET ADDRESS 100 East Main Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dorothy Cramer Kerrigan		First	Middle	Last	4. DATE DEATH October 27, 1960	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1898	9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David Cramer		14. MOTHER'S MAIDEN NAME Frances Mercier							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-40-3557		INFORMANT J. Ward Kerrigan, 100 East Main Emmitsburg, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 10IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. { DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from now , 19 69 , to 27 Oct , 19 60 that I last saw the deceased alive on 27 Oct , 19 60 , and that death occurred at 7 30 P M, from the causes and on the date stated above.								22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>George L. Morninester</i>		M.D.						DATE SIGNED 10/28/60	
PHYSICIAN'S NAME (Type) GEORGE L. MORNINESTER, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 31, 1960		22c. NAME OF CEMETERY OR CREMATORIUM New St Joseph's		22d. LOCATION (City, town, or county) Emmitsburg, Frederick Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR Oct 31 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
VS A15 (4) 15M 9/58									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be referred by the hospital or attending physician.

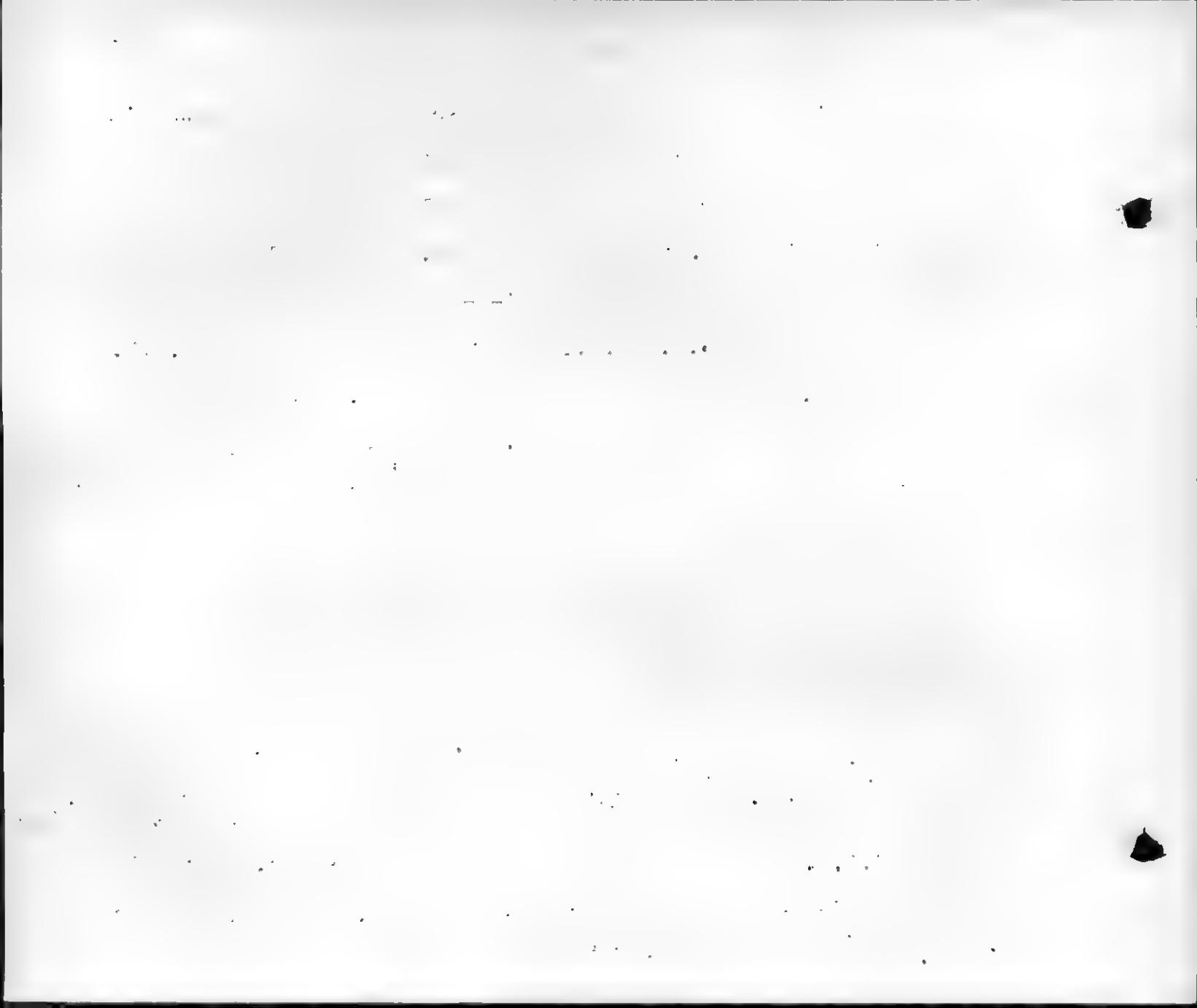
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11371
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 801 East "D"		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
3. NAME OF DECEASED (Type or print) Richard		First Creighton	Middle Kline Sr.
4. DATE OF DEATH 10 25 1960		Month 10	Day 25
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10-5-1903		9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 0
11. BIRTHPLACE (State or foreign country) Maryland		12. IF UNDER 24 HRS Days 0	13. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary engineer		10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co	
13. FATHER'S NAME Hugh C. Kline		14. MOTHER'S MAIDEN NAME Ella Moler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Zoe Kline, Brunswick, Maryland	
17. ADDRESS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____	
DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/25/1960 to 10/25/1960 at Brunswick , Maryland, from the causes and on the date stated above. alive on 10/25/1960 , and that death occurred at 10/25/1960 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Maryland		DATE SIGNED 10/25/1960	
ACTUAL SIGNATURE J.G.F. Smith		M.D.	
PHYSICIAN'S NAME (Type) J.G.F. Smith		Brunswick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-28-1960	
22c. NAME OF CEMETERY OR CREMATORIAL Park Heights		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. J. Feeney		ADDRESS Brunswick, Maryland	
		24a. REC'D BY REGISTRAR Oct 31 '60	
		24b. REGISTRAR'S SIGNATURE John S. Frank	



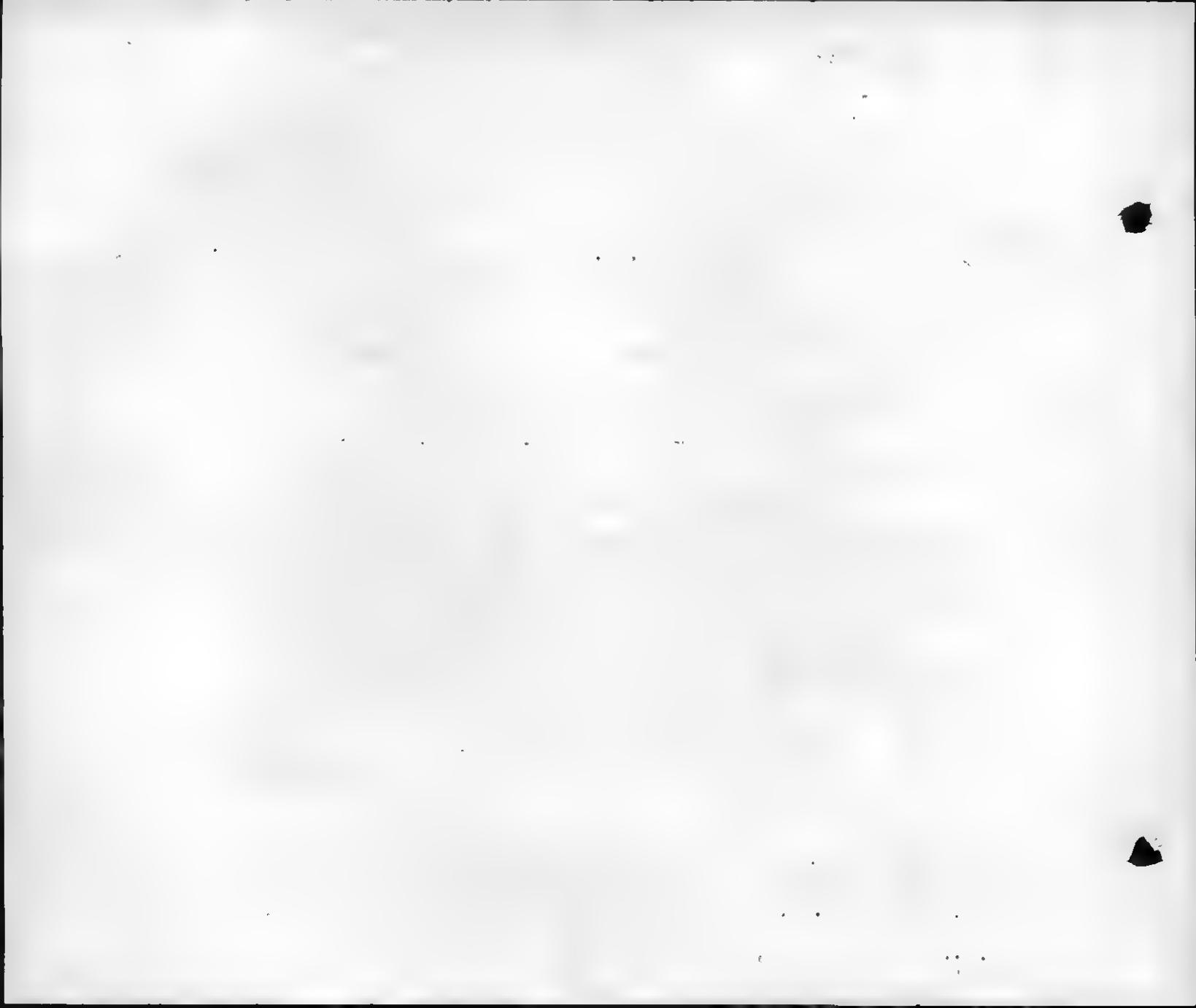
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11383

CERTIFICATE OF DEATH

11372

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		d. STREET ADDRESS 105 EAST CHURCH STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Viola	Middle E. A.	Last KLINE	4. DATE OF DEATH October 22, 1960	Month October	Day 22	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-1900	9. AGE (In years last birthday) 60 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OLIVER Joshua		14. MOTHER'S MAIDEN NAME BESSIE V SPEARS		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 215-14-2671		17. INFORMANT Mr. David W. Kline-Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 5810 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Beriberi Heart disease Cirrhosis of Liver		INTERVAL BETWEEN ONSET AND DEATH 1 month 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 11, 1960 to Oct. 22, 1960 , that (I) (we) last saw the deceased alive on Oct. 22, 1960 , and that death occurred at 3:00 PM from the causes and on the date stated above.							
22a. SIGNATURE Bernard O. Thomas Jr		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/22/60			
22c. PHYSICIAN'S NAME (Type) Bernard O. Thomas Jr		22d. ADDRESS Fredrick, Md					
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 25, 1960		23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 26 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thrua	





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11384 11373

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 18 yrs.		2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wynelle Nursing Home-632 Military Road						d. STREET ADDRESS 322 Park Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Teresa Catherine Klipp		First	Middle	Lost	4. DATE OF DEATH Oct. 17	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 23-1888	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John A. Korrell				14. MOTHER'S MAIDEN NAME Cornelia C. Burrier					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-28-6055		17. INFORMANT Mr. David C. Klipp-322 Park Ave. Frederick-Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		<i>Carcinoma of L. breast with metastasis.</i>				INTERVAL BETWEEN ONSET AND DEATH 3 years			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									
<i>170</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 9-21 1959		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 9-21 1959 to 10-17-1960 , that (I) (we) last saw the deceased alive on 10-16 1960 , and that death occurred at 3:30A from the causes and on the date stated above									
22a. SIGNATURE <i>Rex R. Martin</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-17-60			
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		22d. ADDRESS 220 N. Market St.-Frederick- Maryland							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-1960		23c. NAME OF CEMETERY OR CREMATORIUM Rocky Springs Cemetery		23d. LOCATION (City, town, or county) W. of Frederick- Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Dailey & Funeral Home</i>		ADDRESS Frederick- Maryland		25a. REC'D BY REGISTRAR DATE OCT 20 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Price</i>			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11413

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11374

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural R.D.#6		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Popular Heights		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural R.D.#6	
3. NAME OF DECEASED (Type or print) WILLIAM WALTER LEFFEL		d. STREET ADDRESS Poplar Heights	
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month October Day 3, 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1880	
9. AGE (in years at birthday) 80		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Farmer		10b. KIND OF BUSINESS OR INDUSTRY General	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Preston Leffel		14. MOTHER'S MAIDEN NAME Fannie Ellen Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ruby K. Neel-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>H2O</i> DUE TO Arterosclerosis, heart disease Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) asthma (c) chronic bronchitis			
INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Pulmonary emphysema			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-2 , 19 57 , to 10-3- , 19 60 , that (I) (we) last saw the deceased alive on 2-2 , 19 60 and that death occurred at 345 P.M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Rex R. Martin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 10/3/60	
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.		22d. ADDRESS North Market Street, Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Shawver Cemetery		23d. LOCATION (City, town, or county) Tazewell County, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE OCT 6 '60	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11401

CERTIFICATE OF DEATH

11375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 Greenwood Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
3. NAME OF DECEASED (Type or print) Martha		First J.	Middle Lowery
4. DATE OF DEATH 10		Month 10	Day 31
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 9-30-1886		9. AGE (In years next birthday) 74	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob Waters		14. MOTHER'S MAIDEN NAME Francis E. Owens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Francis Eury, Brunswick, Maryland	
17. ADDRESS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		2 days	
(b) Congestive Heart Failure DUE TO Possible Intestinal Carcinoma		3 years 1 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 6, 1960, to Oct. 31, 1960, that I last saw the deceased alive on Oct. 31, 1960, and that death occurred at 12:25 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 15 S. Maryland Ave. DATE SIGNED Nov. 2, 60	
ACTUAL SIGNATURE 			
PHYSICIAN'S NAME (Type) C.T. Byron Kao, M.D.		Brunswick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-1960	
22c. NAME OF CEMETERY OR CREMATORIAL Park Heights		22d. LOCATION (City, town, or county) Brunswick, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR NOV 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Traas	
DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

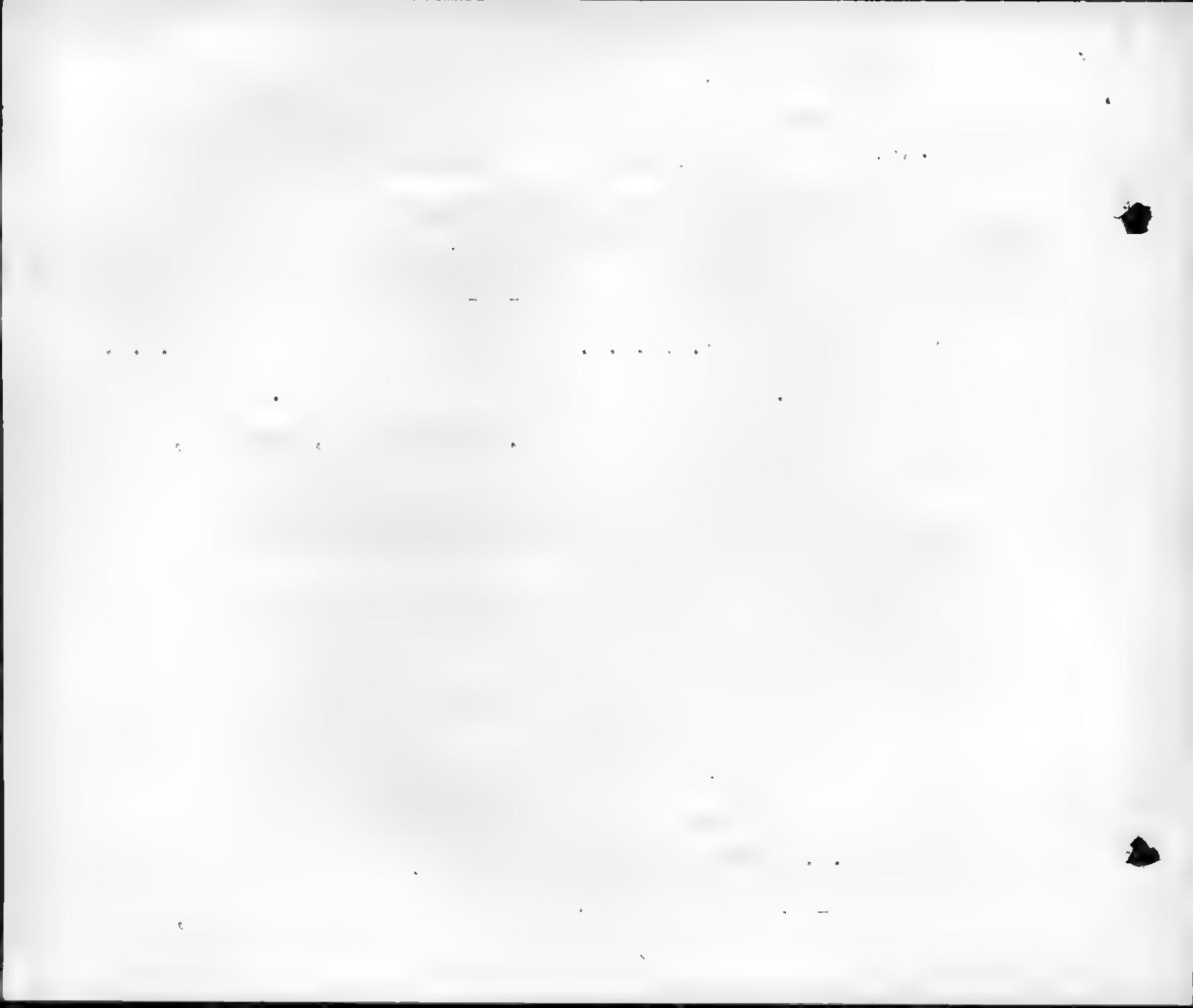


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11376

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 14 West Potowmack	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mr. James	First James	Middle 	4. DATE OF DEATH Oct 17 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-1889
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Mitchell		14. MOTHER'S MAIDEN NAME Ellen V. Lowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 	
17. INFORMANT Mrs. Reva Mitchell, Brunswick, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from Oct. 17 1960 to Oct. 17 1960 that (I) (we) last saw the deceased alive on Oct. 17 1960 and that death occurred at 4:45 P.M. from the causes and on the date stated above			
22a. SIGNATURE A. A. Pearce		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. A. Pearce		22d. ADDRESS Frederick, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-20-1960	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Samples Manor		23d. LOCATION (City, town, or county) (State) Samples Manor, Md	
24. FUNERAL DIRECTOR'S SIGNATURE S. L. Knut		25a. REC'D BY REGISTRAR DATE OCT 20 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Knut	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11386

CERTIFICATE OF DEATH

11377

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

X

I

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		d. STREET ADDRESS 513 NORTH MARKET STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 513 NORTH MARKET STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First CORA	Middle MARGARET	Last MURPHY	4. DATE OF DEATH	Month OCTOBER	Day 19	Year 1960		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 30, 1867	9. AGE (In years last birthday) 93	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LEWIS W. RIDDLEMOSER			14. MOTHER'S MAIDEN NAME ALICE STUP						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT ROBERT L. MURPHY, 116 DIAMOND AVE. GAITHERSBURG, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		<i>Acute Cardiac Failure</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>434.9</i>			DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<i>Acute pulmonary Edema</i>			DUE TO				
		<i>Acute pulmonary Edema</i>			DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from Oct. 17, 1960 to Oct. 19, 1960 , that I last saw the deceased alive on Oct. 19, 1960 , and that death occurred at 9:30 a.m. M, from the causes and on the date stated above.					ADDRESS (Street, city or town, state)			DATE SIGNED	
ACTUAL SIGNATURE <i>B.D. Thomas</i>					M.D. Professional Building, Frederick, Md.				
PHYSICIAN'S NAME (Type) B.D. Thomas M.D.					<i>Oct. 19, 1960</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/22/60		22c. NAME OF CEMETERY OR CREMATORIUM MOUNT OLIVET CEMETERY		22d. LOCATION (City, town, or county) FREDERICK, MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M.R. ETCHEISON & SON, 106 EAST CHURCH ST. FREDERICK		ADDRESS MARYLAND.		24a. REC'D BY REGISTRAR DATE OCT 24 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

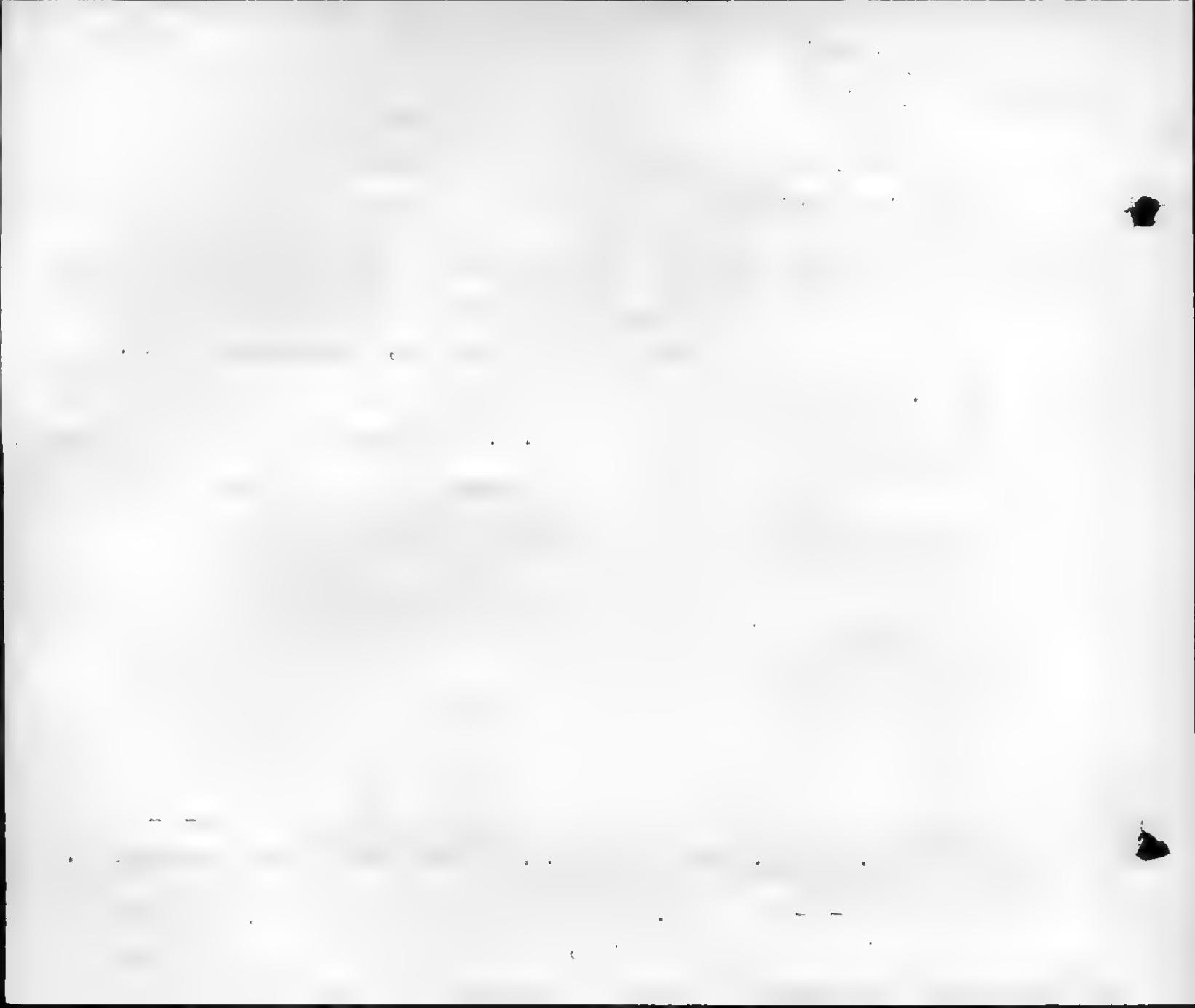


M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11387 11378

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Monocacy Hall Nursing Home		d. STREET ADDRESS 625 Wilson Place	
3. NAME OF DECEASED (Type or print) Nellie Donnelly		First Middle Patterson	4. DATE OF DEATH October 13, 1960
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Uniontown, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. Donnelly		14. MOTHER'S MAIDEN NAME Lena Bauer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. H. Albert Dean 625 Wilson Place Frederick,
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 199 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any (b) (c)		DUE TO Generalized and Cereinomatosis original source undetermined INTER Maryland ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Anteriorolateral Cerebrovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 1958 to Oct. 13, 1960, that (I) (we) last saw the deceased alive on Oct. 13, 1960, and that death occurred at 10 PM, from the causes and on the date stated above.		22b. DATE SIGNED 10-14-1960	
22a. SIGNATURE Henry V. Chase		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 10-14-1960
22c. PHYSICIAN'S NAME (Type) Dr. Henry V. Chase		22d. ADDRESS 4 East Church Street Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-17-1960	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Joseph's Cemetery Frederick, Maryland		23d. LOCATION (City, town, or county) Connellsville, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dickey Jr.		25a. REC'D BY REGISTRAR DATE OCT 18 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Traus	



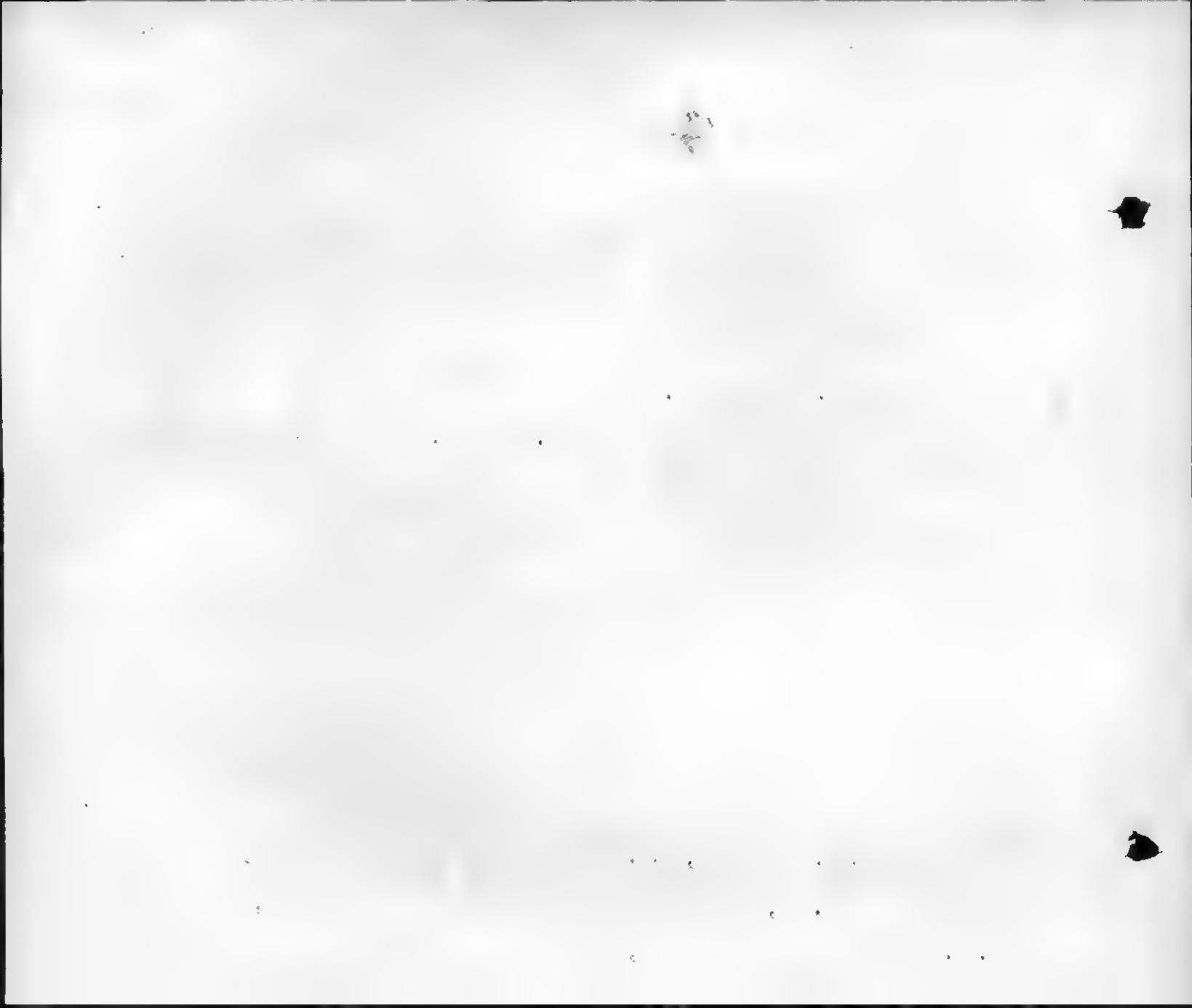
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11379

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 106 East Seventh Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ELSIE	Middle MAY	Last PETTINGALL	4. DATE OF DEATH October 26, 1960	Month October	Day 26	Year 1960	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1889		9. AGE (in years less birthday) 71	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 0 Hours 0 Min. 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles R. Moberly, Sr.				14. MOTHER'S MAIDEN NAME Rosa Brengle					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Harry E. Pettingall-Same as Item #2		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Coronary Sclerosis									INTERVAL BETWEEN ONSET AND DEATH 3 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Deabetes M + H. tis									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/26 1960 , and that death occurred at 4:50P , from the causes and on the date stated above.		22. DATE SIGNED 10/28/60							
22c. PHYSICIAN'S NAME (Type) L. R. Schoolman, M.D.		22d. ADDRESS 816 East 7th Street, Frederick, Maryland							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 29, 1960		23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION (City, town, or county) Frederick, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE NOV 1 '60							
		25b. REGISTRAR'S SIGNATURE Charles S. Evans							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11380

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 219 South Market Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) SUSIE		4. DATE OF DEATH Month October Day 13, 1960	
First SUSIE		Middle ISABELL	
Last RAMSBURG		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH October 14, 1877		9. AGE (In years (last birthday) yrs) 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. O. Baumgardner		14. MOTHER'S MAIDEN NAME Fannie Sinn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-5274	
17. INFORMANT Mr. Jesse C. Ramsburg—Same as Item #1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i>		1 week	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arteriosclerotic Heart Disease</i>		1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1951 to Oct 13, 1960 , that (I) (we) last saw the deceased alive on Oct 13, 1960 , and that death occurred at 7:30A , from the causes and on the date stated above		22b. DATE 10/15/60	
22a. SIGNATURE <i>Thomas E. Stone</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D.		22d. ADDRESS West Third Street, Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 17, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE OCT 19 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11381

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Addie	Middle Susan	Last Roach
4. DATE OF DEATH	Month Oct	Day 12	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/1876
9. AGE (In years lost (birthday) yrs 84)	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Graybill Naill	14. MOTHER'S MAIDEN NAME Mary Ellen Miller	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Mr. Richard Naill, Silver Spring, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Diabetes mellitus</i> - DUE TO 16 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Maintain diabetes - to injury</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1960 , to Oct 12, 1960 , that (I) (we) last saw the deceased alive on Oct 12, 1960 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE <i>E. A. Dettbarn</i>		22b. DATE SIGNED Oct 14, 1960	
22c. PHYS. CIAN'S NAME (Type) Dr. E. A. Dettbarn	M. D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>116 E. Main St., P.O. Box 100, Walkersville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 10/16/60	23c. NAME OF CEMETERY OR CREMATORIUM Keedysville Cemetery	23d. LOCATION (City, town, or county) (State) Keedysville, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.	ADDRESS Middletown, Md.	25a. REC'D BY REGISTRAR Oct 18 '60	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11391

11382

Item 13 will be G273 11-14-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keymar R.F.D.2		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Carrie		First	Middle	Lost	4. DATE OF DEATH October 5 1960	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 24, 1907	9. AGE (In years from birthday) 52 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Marcella Blanche Staub						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-01-2036		17. INFORMANT Mrs Margaret Smith, Walkersville R.D.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>D&X</u> DUE TO Pontine Hemorrhage, Acute and Massive INTERVAL BETWEEN ONSET AND DEATH 1 hr. Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Lodestburg	(County) Md	(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>B.O. Thomas</i>		EXAMINER'S NAME (Type) B.O. Thomas, M.D.		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10/6/60		
22a. BURIAL, CREMATION REMOVAL, (Specify) Burial		22b. DATE THEREOF Oct 8-1960	22c. NAME OF CEMETERY OR CREMATORIUM Haugh's	22d. LOCATION (City, town, or county) Lodestburg		(State) Md		
23. FUNERAL DIRECTOR'S SIGNATURE G G Barton		ADDRESS Walkersville		24a. REC'D. BY REGISTRAR Oct 10 60	24b. REGISTRAR'S SIGNATURE Charles J. Moore			
VS. A15ME SM 2/57								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												11383	
11392						CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b Hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital						d. STREET ADDRESS Urbana						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DEE		First WILLIAM		Middle SCHAFFER		Last		4. DATE OF DEATH October 30, 1960		Month October Day 30 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 July 1912		9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer						10b. KIND OF BUSINESS OR INDUSTRY Farm Owner						11. BIRTHPLACE (State or foreign country) Nokesville, Virginia	
13. FATHER'S NAME David Schaeffer						14. MOTHER'S MAIDEN NAME Anna Fue						12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO. 215-36-6392						17. INFORMANT Mrs. Constance Schaeffer (Same as item #2) Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.												Acute myocardial infarction, secondary Arteriosclerotic heart disease with myocardial infarction 5 years ago	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Frederick (County) Maryland (State) Md.				
21. I certify that (I) (this hospital) attended the deceased from 1955 to 10-30-1960 , that (I) (we) last saw the deceased alive on 10-30-1960 , and that death occurred 11:30A , from the causes and on the date stated above.													
22a. SIGNATURE 						M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED 1 Nov 1960	
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.						22d. ADDRESS 220 N. Market St., Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11-2-60			23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery			23d. LOCATION (City, town, or county) Frederick, Maryland			(State)	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland						ADDRESS M. R. Etchison & Son, Frederick, Maryland			25a. REC'D BY REGISTRAR DATE NOV 3 '60		25b. REGISTRAR'S SIGNATURE 		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

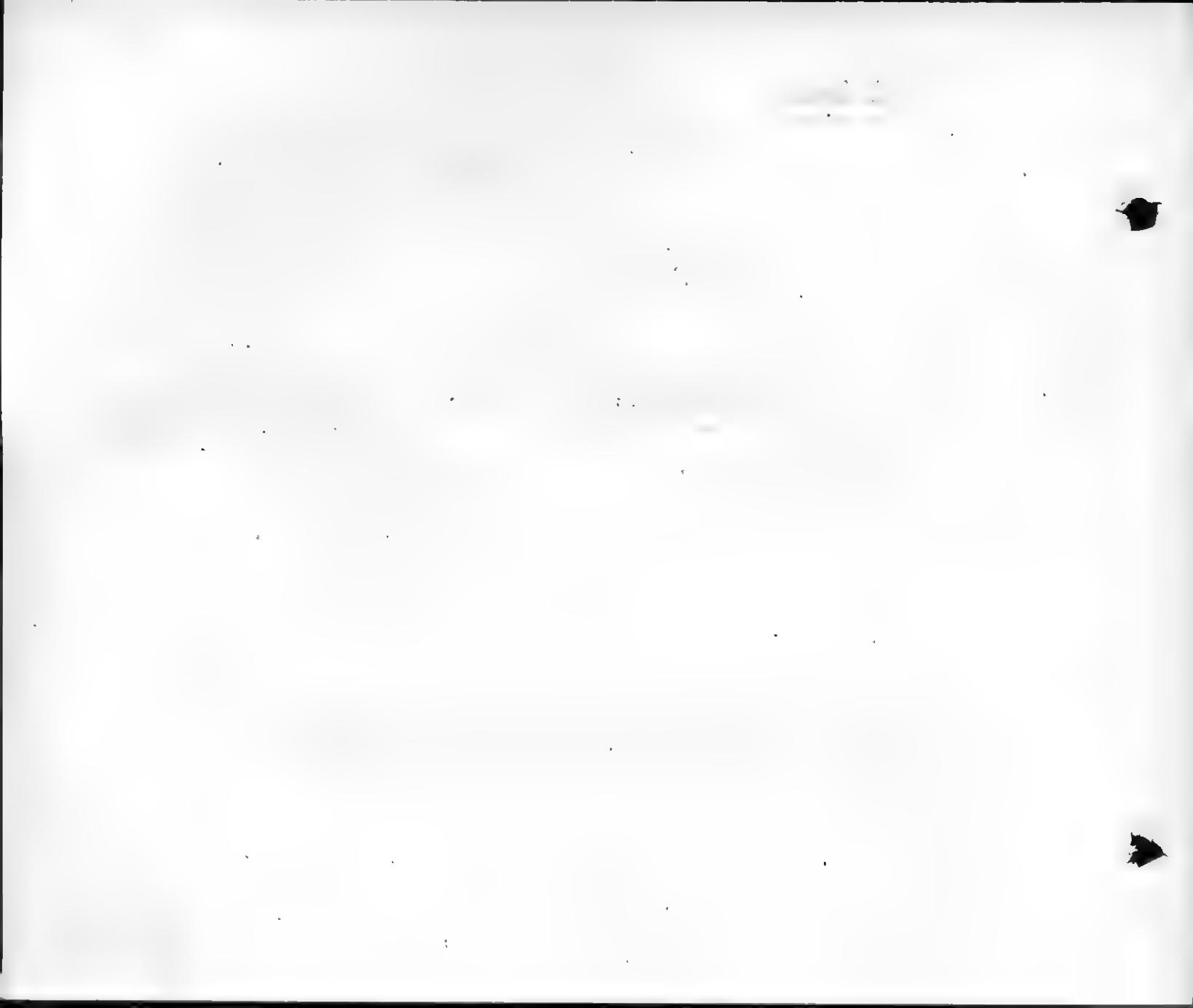
11414

11384

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Frederick Co. Md.</i>		b. COUNTY	
b. CITY OR TOWN (If out'side corporate limits, write RURAL and give nearest town) <i>New Midway</i>		c. LENGTH OF STAY IN 1b <i>1 1/2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR (INSTITUTION)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X R.D. Linthicum Md.</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Harry</i>	Middle <i>Glen</i>	Last <i>Shank</i>
4. DATE OF DEATH	Month <i>Oct</i>	Day <i>24</i>	Year <i>1960</i>
5. SEX <i>M</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>70 yrs</i>
9. AGE (In years last birthday) <i>70 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <i>Retired Painter</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Frederick Furniture Co.</i>	12. BIRTHPLACE (State or foreign country) <i>Woodsboro Frederick Co. Md.</i>
13. FATHER'S NAME <i>Charles B. Shank</i>	14. MOTHER'S MAIDEN NAME <i>Sarah Curran</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>217-28-1044</i>	17. INFORMANT <i>Bethia E. Shank</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>420</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis, cardiovascular disease</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20. INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) <i>Soft bullet in the brain</i>	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>WALKERSVILLE, MD</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 1st</i> , 19 <i>50</i> , to <i>24 Oct</i> , 19 <i>60</i> that I last saw the deceased alive on <i>24 October</i> , 19 <i>60</i> , and that death occurred at <i>10:20</i> AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>James E. Stover, Jr.</i>	ADDRESS (Street, city or town, state) <i>WALKERSVILLE, MD</i>		DATE SIGNED <i>10/25/60</i>
22a. PHYSICIAN'S NAME (Type)	22b. BURIAL CREMATION, REMOVAL (Specify) <i>Cremated</i>	22c. DATE THEREOF <i>10-27-60</i>	22d. NAME OF CEMETERY OR CREMATORIAL <i>W. Hope</i>
22d. LOCATION (City, town, or county) <i>Hindsboro</i>	22e. ADDRESS <i>Hindsboro</i>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond T. Wright</i>	24a. REC'D BY REGISTRAR DATE <i>OCT 31 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Trahan</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be registered by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

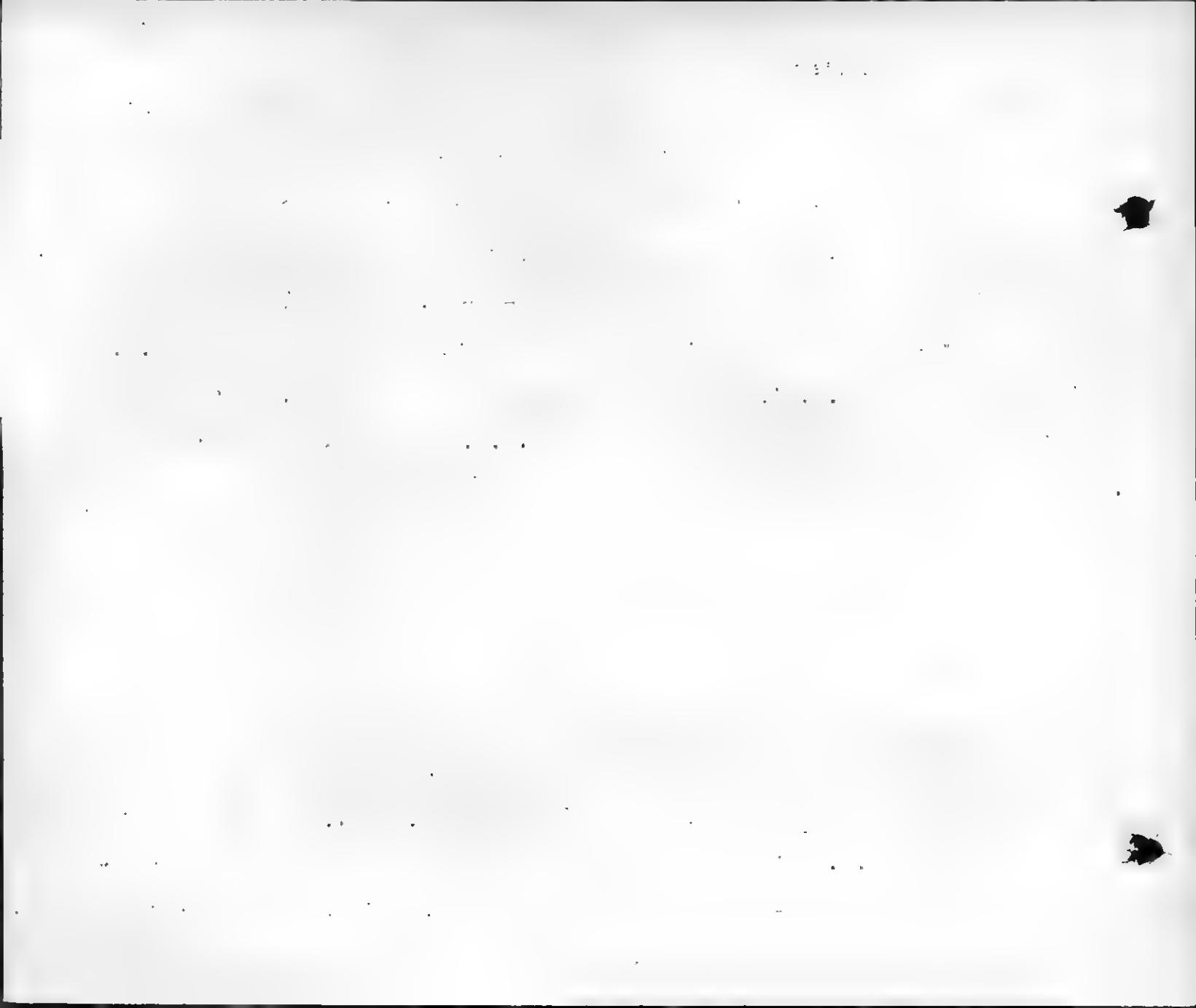
11385

11402

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 West "C" Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
3. NAME OF DECEASED (Type or print) Naomi		First Elizabeth	Middle Sigafoose
4. DATE OF DEATH 10 21 1960		Last	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1914
9. AGE (In years last birthday) 46 yrs.		10. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME J.M. Sigafoose	
14. MOTHER'S MAIDEN NAME Cora E. Kaetzel		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		INFORMANT Mr. J.M. Sigafoose, Brunswick, Maryland	Address
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		18. INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-1-1960 to 10-21-1960, that I last saw the deceased alive on 10-21-1960, and that death occurred at 4:55 AM, from the causes and on the date stated above.			
ACTUAL INFORMATION PHYSICIAN'S NAME (Type) C.E. Pruitt		ADDRESS (Street, city or town, state) Brunswick, Maryland DATE SIGNED 10-24-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-24-1960	22c. NAME OF CEMETERY OR CREMATORIAL Brownsville Heights	22d. LOCATION (City, town, or county) (State) Brownsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Pruitt		ADDRESS Brunswick, Maryland	24a. REC'D BY REGISTRAR DATE OCT 26 '60
			24b. REGISTRAR'S SIGNATURE Charles L. Pruitt



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

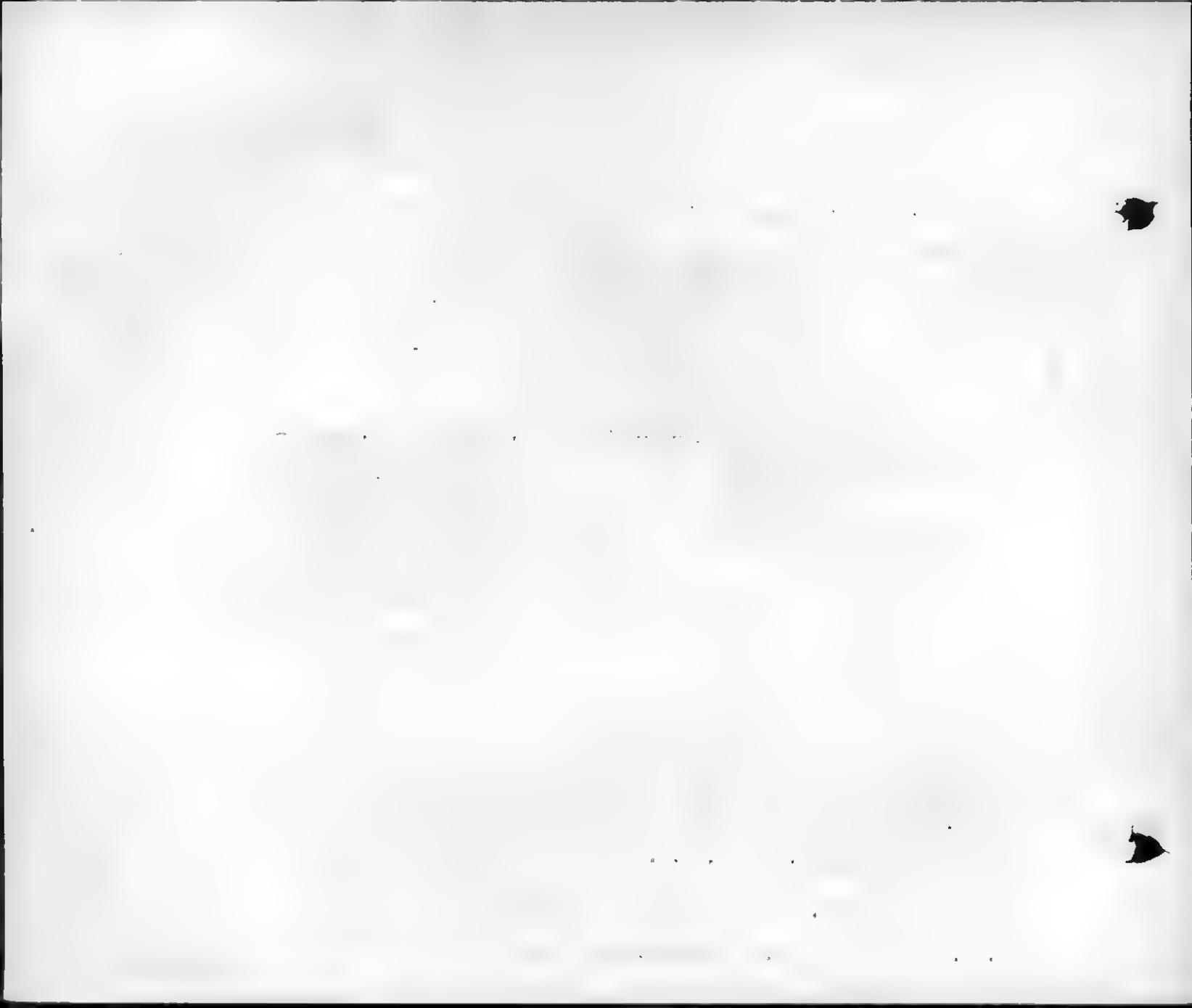
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11386

11393

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE																					
Frederick MARYLAND				Maryland b. COUNTY																					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick																			
Frederick		Years		d. STREET ADDRESS		107 Record Street																			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
Frederick Memorial Hospital																									
3. NAME OF DECEASED (Type or print)		First EDWARD	Middle JOSEPH	Last SMITH	4. DATE OF DEATH	Month October	Day 29,	Year 1960																	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years less birthday) 81 yrs		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Hours 0													
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 16, 1879		12. CITIZEN OF WHAT COUNTRY?		USA															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?													
Lawyer				Own				Maryland				USA													
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT									
Francis Fenwick Smith				Maria Lee Palmer				Mo				216-38-0945				Mrs. Charlotte P. Smith-Same as Item #2									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										Address															
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										INTERVAL BETWEEN ONSET AND DEATH															
H2O. c DUE TO										1 day															
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.										(b) Arteriosclerotic Heart disease DUE TO															
(c)										10 yrs t															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
Bronchopneumonia.																									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from November 1954 to Oct 28, 1960, that (I) (we) last saw the deceased alive on Oct 28, 1960, and that death occurred at 5:30P, from the causes and on the date stated above.				22a. SIGNATURE				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 10/29/60													
Henry V. Chase				22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS				East Church Street, Frederick, Maryland													
Henry V. Chase, M.D.																									
23a. BURIAL, CREMATON, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORI				23d. LOCATION (City, town, or county)				(State)													
Burial		Oct. 31, 1960		Mount Olivet Cemetery				Frederick,				Maryland													
24. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE													
M. R. Etchison & Son, Frederick, Maryland								DATE NOV 1 '60				Arthur S. Evans													



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11387

11394

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>+ Mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wynelle Nursing Home</i>		e. STREET ADDRESS <i>x Walkersville</i>	
3. NAME OF DECEASED (Type or print) <i>HARVEY E. SMITH</i>		4. DATE OF DEATH <i>Oct. 9 1960</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 6 1872</i>
9. AGE (In years last birthday) <i>88 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Drayman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Business</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Solomon E. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Lookingbill</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-01-0649</i>	
17. INFORMANT <i>Mrs. E. J. Fisher, 110 N. Court St., Fred, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>Arteriosclerotic, cardiovascular disease</i> (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Cerebral thrombosis & right homoplegia - 6 weeks duration</i>		21. I certify that I attended the deceased from <i>September 1959</i> to <i>9 October 1960</i> that I last saw the deceased alive on <i>8 October 1960</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Walkersville, Md</i>	
22. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		22c. ACTUAL SIGNATURE <i>James E. Stoner</i> M.D. 22d. DATE SIGNED <i>10/10/60</i>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 10/11/60		22f. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton</i>		24a. ADDRESS <i>Walkersville, Md</i>	
24b. REC'D BY REGISTRAR DATE <i>OCT 13 '60</i>		24c. REGISTRAR'S SIGNATURE <i>Charles S. Kimes</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: I am required that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11415

11388

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick—Rural—R.F.D.#5		c. LENGTH OF STAY IN 1b Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Convalescent & Rest Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick R.F.D.#5	
3. NAME OF DECEASED (Type or print) Maurice LUTHER		4. DATE OF DEATH Stockman	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural Mail Carrier		10b. KIND OF BUSINESS OR INDUSTRY Star Route	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther Francis Stockman		14. MOTHER'S MAIDEN NAME Harriett Gatton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Elsie V. Burkett, Frederick, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 234X DUE TO Fusogenic disease Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral arteriosclerosis (c) DUE TO Angertive heart failure	
		INTERVAL BETWEEN ONSET AND DEATH 1 year 1 year 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1 Sept</u> , 19 <u>60</u> , to <u>8 Oct</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8 Oct</u> , 19 <u>60</u> , and that death occurred at <u>63A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Thomas C. Stone</u> M.D. <u>4 West 3rd St, Frederick, Maryland</u> <u>10-1-63</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 11, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery
22d. LOCATION (City, town, or county) Frederick County, Maryland		24a. REC'D BY REGISTRAR DATE OCT 11 '60	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

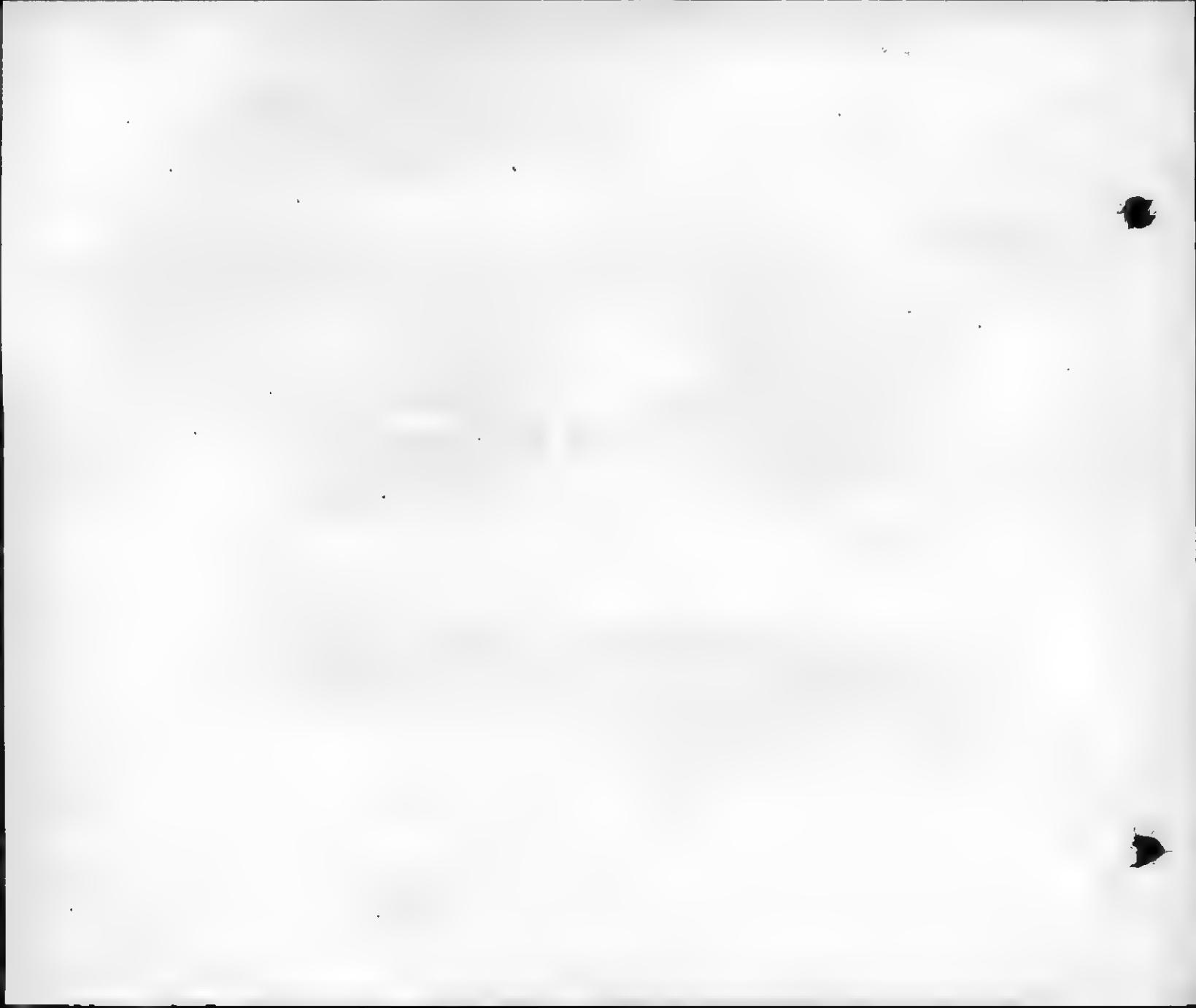
11389

11395		2 USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission)																									
1. PLACE OF DEATH a. COUNTY		a. STATE																									
Frederick		b. COUNTY																									
MARYLAND		Maryland																									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)																									
Frederick		Frederick-Rural- R.F.D.#7																									
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS																									
Days		Yellow Springs																									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																									
Frederick Memorial Hospital																											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year																			
CARRIE		ELIZABETH	STONE	October	6,	19	60																				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Days Hours Min.															
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 16, 1881		79 yrs.		Months		Days Hours Min.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?																		
Housework			At Home			Frederick County			USA																		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)						16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						19. INTERVAL BETWEEN ONSET AND DEATH	
William Harris					Ella Lewis					No						None		Mrs. Ruth A. Droneburg, Frederick, Maryland		Arterio-sclerotic Heart Disease						7 10-20 yrs	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					DUE TO					Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b)		DUE TO		Generalized Arterio-sclerosis						(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					PART III. MEDICAL CERTIFICATION						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
Acute - pyelonephritis					20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 5 1960 to Oct 6 1960, that (I) (we) last saw the deceased alive on Oct 5 1960 and that death occurred at 1:35 P.M. from the causes and on the date stated above.					22a. SIGNATURE R. L. Michels						M.D.		ATTENDING PHYS		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/7/60								
22c. PHYSICIAN NAME (Type)					22d. ADDRESS						Frederick Shopping Center, Md.																
R. L. Michels, M.D.					Frederick Shopping Center, Md.						Frederick Shopping Center, Md.																
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county)		(State)																			
Burial		Oct. 8, 1960		Pleasant Hill Cemetery		Frederick County, Maryland																					
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
M. R. Etchison & Son, Frederick, Maryland					DATE OCT 10 '60					DATE		Signature															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-used by the hospital or attending physician and completely filled in by the funeral director, if this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and if in event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												11390					
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE													
Frederick				Maryland				Maryland				b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 6 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Union Bridge Md RD#2				d. STREET ADDRESS Jolimsville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH				Month	Day	Year				
Roy				Clayton	Taylor		October 23						1960				
5. SEX				6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH				9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min				
Male				White			Aug. 4 1897				63	Yrs.	11. IF UNDER 24 HRS				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
Butcher, packing plant								Baltimore, Md				U.S.A.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME													
Norris Taylor				Samie Ebaugh													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
(If yes, give war or dates of service)				216-07-4186				Mrs. Raymond B. Poole, Union Bridge, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												7 days					
33 CX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.												DUE TO					
												(b)					
												DUE TO					
												(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)		(County)	(State)		
21. I certify that (1) (this hospital) attended the deceased from 10/12/1960 to 10/23/1960, that (1) (we) last saw the deceased alive on 10/22/1960 and that death occurred at 8:54AM, from the causes and on the date stated above												22a. SIGNATURE					
Richard C. Reynolds												M. D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION (City, town, or county) (State)					
Burial				10/25/60				Carnation Church of God Cemetery				Baltimore, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
J. S. Myers Jr., Westminster, Md.								DATE OCT 25 '60				John S. Myers					



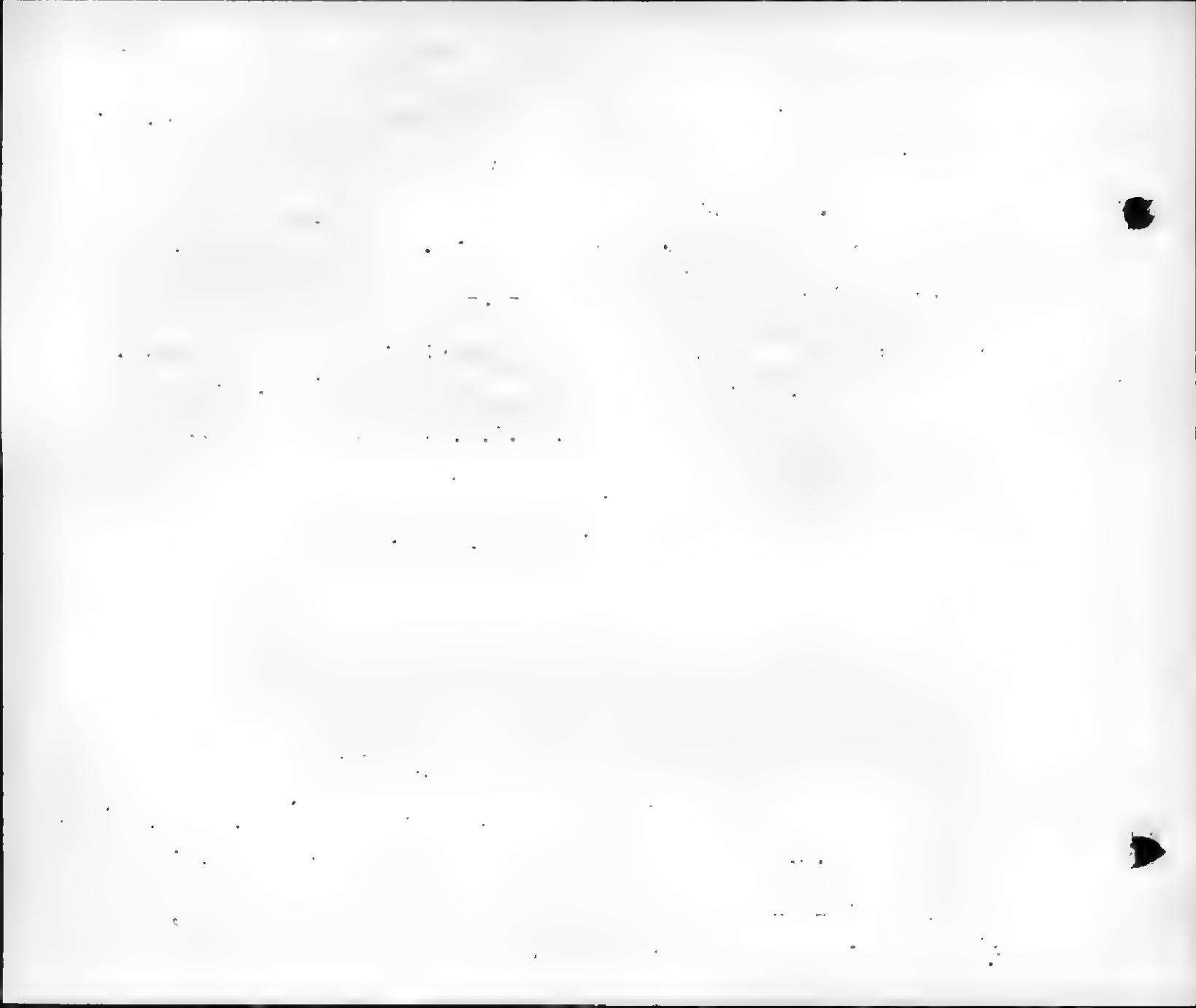
TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11391
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 340		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville	
3. NAME OF DECEASED (Type or print) Edna		First Catherine	Middle Uutterback
4. DATE OF DEATH 10		Month 10	Day 16
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-15-1904		9. AGE (In years last birthday) 58	10. IF UNDER 1 YEAR Months 58
11. BIRTHPLACE (State or foreign country) Maryland		12. IF UNDER 24 HRS Days 58	13. IF UNDER 24 HRS Hours 58
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME John W. Stewart	
16. MOTHER'S MAIDEN NAME Maggie C. Scott		17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
18. SOCIAL SECURITY NO. 123-45-6789		19. INFORMANT Mrs. J.C. Seward, Brunswick, Maryland	Address 123-45-6789
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary embolism		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.	
DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Essential hypertension		1/2 yrs.	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Hour a. m. p. m. 19		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
23. I certify that I attended the deceased from 10-15-1960 to 10-16-1960 that I last saw the deceased alive on 10-15-1960 , and that death occurred at 11:30 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 10-17-60	
24a. ACTUAL SIGNATURE C.E. Pruitt		24b. PHYSICIAN'S NAME (Type) C.E. Pruitt	
25a. BURIAL, CREMATION, REMOVAL (Specify) Burial		25b. DATE THEREOF 10-19-1960	
25c. NAME OF CEMETERY OR CREMATORIAL Samples Manor		25d. LOCATION (City, town, or county) (State) Samples Manor, Md.	
26. FUNERAL DIRECTOR'S SIGNATURE B. L. Felt		26a. ADDRESS Brunswick, Maryland	
26b. REC'D BY REGISTRAR DATE OCT 20 '60		26c. REGISTRAR'S SIGNATURE Arthur L. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

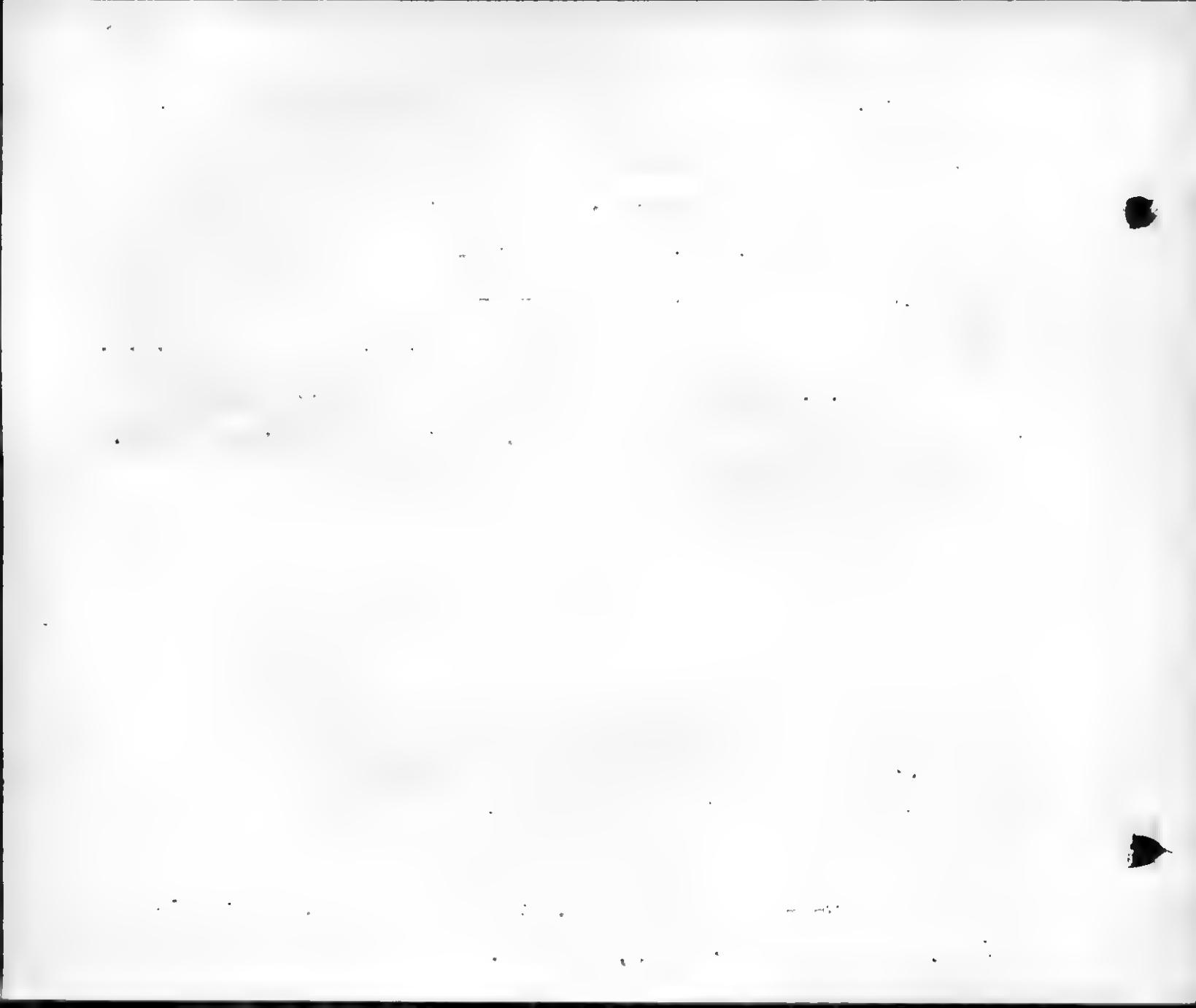
11403

CERTIFICATE OF DEATH

11392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 North Virginia Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
3. NAME OF DECEASED (Type or print) Martha		First Brunswick	Middle Van Osdale
4. DATE OF DEATH 10		Month 10	Day 1
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 5-11-1890		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patrolman		10b. KIND OF BUSINESS OR INDUSTRY School Crossing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME B.F. Sigafoose		14. MOTHER'S MAIDEN NAME Laura V. Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Lena Trexell, Brunswick, Md.	
17. MEDICAL CERTIFICATION 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) Rectum-Carcinoma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 29, 1959, to Oct. 1, 1960, that I last saw the deceased alive on Oct. 1, 1960, and that death occurred at 9:22 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) MD 15 S. Maryland Ave. DATE SIGNED 10-3-60	
PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D.		Brunswick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-4-1960	
22c. NAME OF CEMETERY OR CREMATORIAL Park Heights		22d. LOCATION (City, town, or county) Brunswick, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Eute		ADDRESS Brunswick, Maryland.	
24a. REC'D BY REGISTRAR DATE OCT 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



1
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be ~~referred~~ by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11417 **11393**

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY FREDERICK	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSBORO	c. LENGTH OF STAY IN 1b YEARS							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ODA BELL WEITZ	First Middle Last	4. DATE OF DEATH Oct 12	Month Year 1960					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MAY 26 1885	9. AGE (In years last birthday) 75 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN H. LOCK	14. MOTHER'S MAIDEN NAME ANNIE HUBBARD	15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No	16. SOCIAL SECURITY NO. NONE	INFORMANT J.E. WEITZ	Address Woodsboro Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO (d) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH 2 yrs				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Woodsboro	(County) Maryland	(State) M.D.			
21. I certify that I attended the deceased from Sept 11, 1960 to Oct 11, 1960 , that I last saw the deceased alive on Oct 11, 1960 , and that death occurred at 8:30 M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Union Bridge, MD.	DATE SIGNED Oct 12 1960	
ACTUAL SIGNATURE J.H. MESSINGER	PHYSICIAN'S NAME (Type) J.H. MESSINGER MD	22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF Oct 15 1960	22c. NAME OF CEMETERY OR CREMATORIAL Rocky Hill Cemetery	22d. LOCATION (City, town, or county) Woodsboro Rd. MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. G. Hartman & Sons, Union Bridge						ADDRESS M.D.	24a. REC'D BY REGISTRAR OCT 17 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11394

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

11418

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<p>1. PLACE OF DEATH a. COUNTY Frederick MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont R.F.D.2</p> <p>c. LENGTH OF STAY IN 1b 4 days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Thurmont R.F.D.2</p> <p>d. STREET ADDRESS</p>		<p>3. NAME OF DECEASED (Type or print) Robert Christopher Wetzel</p> <p>First Robert Middle Christopher Last Wetzel</p>		<p>4. DATE OF DEATH October 19 1960</p> <p>Month October Day 19 Year 1960</p>		<p>5. SEX Male 6. COLOR OR RACE White</p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Oct. 12, 1960</p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>9. AGE (in years from birthday) — yrs.</p> <p>IF UNDER 14 YEARS <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/></p> <p>Months 7 Days 0 Hours 0 Min. 0</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) Pa. Adams Co.</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>					
<p>13. FATHER'S NAME Robert M. Wetzel</p>		<p>14. MOTHER'S MAIDEN NAME Margaret Wastler</p>									
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO</p>		<p>16. SOCIAL SECURITY NO. None</p>		<p>17. INFORMANT Robert M. Wetzel, Thurmont, R.F.D.2</p>		<p>Address</p>					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Aspiration Asphyxia</p>						<p>INTERVAL BETWEEN ONSET AND DEATH mins.</p>					
<p>762-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) — (c) —</p>											
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>								<p>19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>			
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)</p>									
<p>20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year p. m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) Emmitsburg (County) Md. (State) Md.</p>					
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>											
<p>ACTUAL SIGNATURE B.O. Thomas, M.D.</p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>				<p>DATE SIGNED Oct 21, 1960</p>			
<p>EXAMINER'S NAME (Type) B.O. Thomas, M.D.</p>				<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>22b. DATE THEREOF 10-22-60</p>		<p>22c. NAME OF CEMETERY OR CREMATORIAL St. Anthony Cemetery</p>		<p>22d. LOCATION (City, town, or county) Emmitsburg (State) Md.</p>					
<p>23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greago</p>				<p>ADDRESS Thurmont, Md.</p>		<p>24e. REC'D BY REGISTRAR OCT 24 '60</p>		<p>24f. REGISTRAR'S SIGNATURE Arthur S. Mann</p>			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11406

11395

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b 13 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
f. STREET ADDRESS East Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Franklin Wilhide		4. DATE OF DEATH Oct. 30	Month Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josiah Wilhide		14. MOTHER'S MAIDEN NAME Julia Freeze	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-26-8352	
17. INFORMANT Mrs. Carrie I. Wilhide		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b) DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (c) DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 16 1960 to Oct. 30 1960, that (I) (we) last saw the deceased alive on Oct. 29 1960, and that death occurred on 2 A.M. from the causes and on the date stated above		22b. DATE SIGNED Oct. 31, 1960	
22a. SIGNATURE M. Franklin Birely		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. M. Franklin Birely		22d. ADDRESS Thurmont, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-1-60	
23c. NAME OF CEMETERY OR CREMATORIAL Rocky Hill Cemetery		23d. LOCATION (City, town, or county) (State) Mr. Woodsboro, Md. Fred. Co.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Braggs		ADDRESS Thurmont, Md.	
25a. REC'D BY REGISTRAR NOV 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frantz	



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1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11396

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

65 years

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Frederick Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

d. STREET ADDRESS

123 South Jefferson Street

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First
J.

Middle
Lee

Last
Willard

4. DATE
OF
DEATH

October 13,

1960

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

May 26, 1889

9. AGE (In years
lost birthday)

71

Yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS

Hours

Min.

Male

White

WIDOWED

DIVORCED

10a. US-JAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Retired Rail Road Trainman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Kirksville, Missouri

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Hower Willard

14. MOTHER'S MAIDEN NAME

Nettie Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

705-09-9289

17. INFORMANT

Mrs. Elaine S. Willard (Wife) 123 Jefferson St.

Address

Frederick, Maryland

ONSET AND DEATH

27 hrs

24 hrs

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

DUE TO

(b)

DUE TO

(c)

Aortic Cordis Failure
Pulmonary Edema
Angina Pectoris

ONSET AND DEATH

27 hrs

24 hrs

24 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year

Hour

o. m.

p. m.

19

20d. INJURY OCCURRED

White
Not white
of work of work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

June 10, 1960, to Oct. 13, 1960, that (I) (we) last

saw the deceased alive on Oct. 7, 1960, and that death occurred at 8 A.M.

22a. SIGNATURE

B. O. Thomas

22b. DATE
SIGNED

10-14-60

22c. PHYSICIAN'S
NAME (Type)

Dr. B. O. Thomas, Sr.

22d. ADDRESS

M.D. 228 North Market Street Frederick, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

Burial 10-15-1960

Mt. Olivet Cemetery

23d. LOCATION (City, town, or county)

(State)

Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

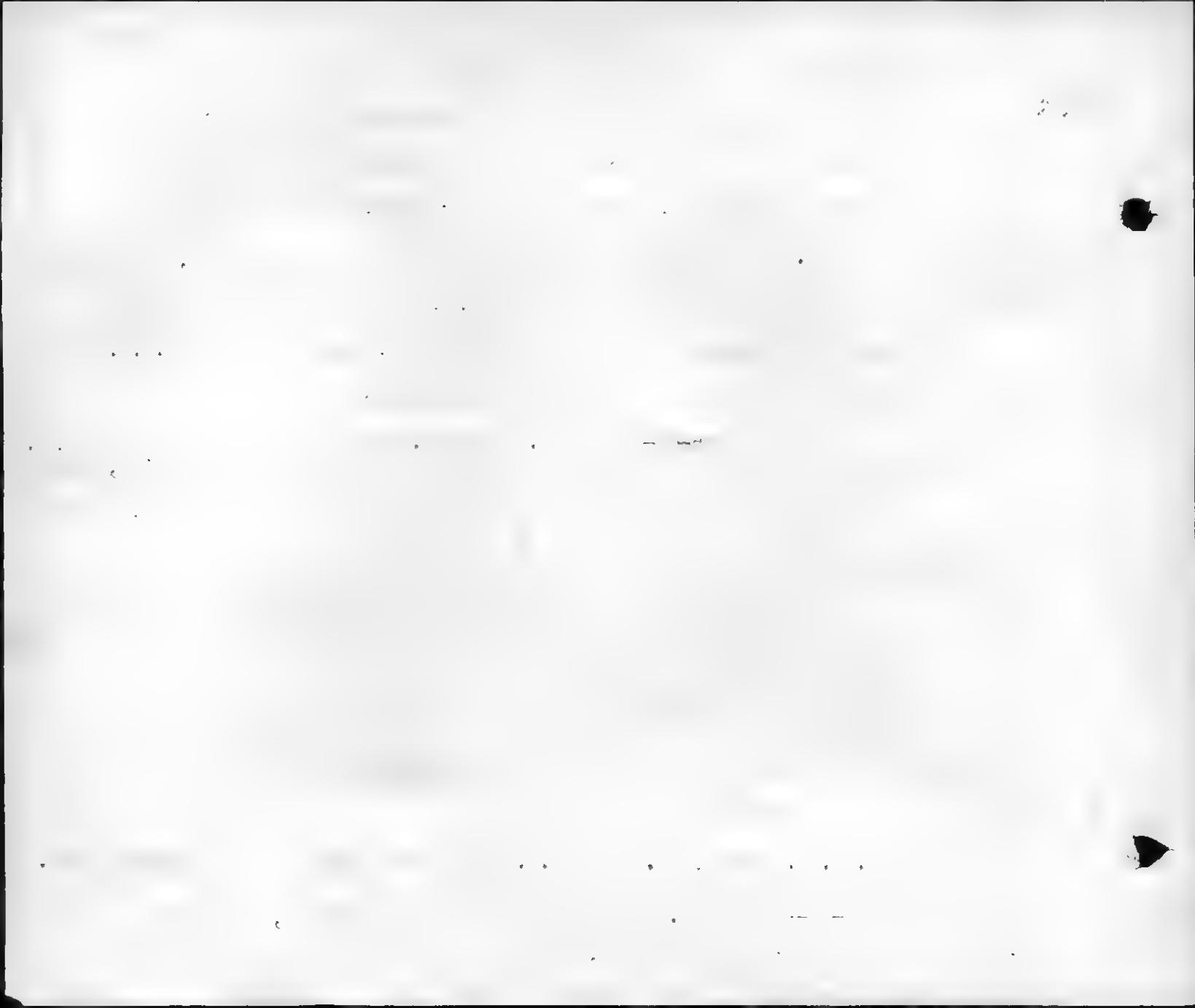
Robert E. Dailey, Jr.,
Frederick, Maryland

25a. REC'D BY REGISTRAR

DATE OCT 18 '60

25b. REGISTRAR'S SIGNATURE

Charles S. Krause



1
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4
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11419

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

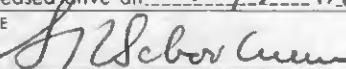
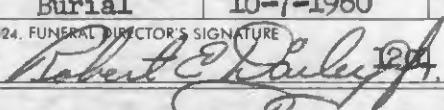
11397

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Braddock Heights		c. LENGTH OF STAY IN 1b 1 1/2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Cora	Middle V.	Last Wolfe
4. DATE OF DEATH October 20,	Month October	Day 20	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1880
9. AGE (In years lost birthday) 80	10. IF UNDER 1 YEAR Months 80	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Frederick Co. Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Ezra Baker	14. MOTHER'S MAIDEN NAME Mary Gilbert		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Daniel W. Wolfe	Address Frederick Rt. #1, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 2-10 , 19 53 , to 10-20- , 19 60 , that (I) (we) last saw the deceased alive on 10-18 , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE <i>Rex Martin</i>		M.D.	22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Dr. Rex Martin
22d. ADDRESS 220 North Market St. Frederick, Md.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 22, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Beaver Dam Cemetery	23d. LOCATION (City, town, or county) Frederick County, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Bailey Jr.</i>	ADDRESS Frederick, Maryland	25a. REC'D BY REGISTRAR DATE OCT 24 '60	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11398

11398

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 70 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 402 Carroll Parkway	
3. NAME OF DECEASED (Type or print) Lena K. Zimmerman		First Lena	Middle K.
Last Zimmerman		4. DATE OF DEATH Month October	Day 5
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 28-1874		9. AGE (In years lost birthday) 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jackson Zimmerman		14. MOTHER'S MAIDEN NAME Margaret Firestone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Clemon Lenhart-402 Carroll Prkwy.-		Address Frederick- Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450-1 DUE TO gangrene of left foot INTERVAL BETWEEN ONSET AND DEATH 3 months			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obliterative end arteritis (c) 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/11 , 1960, to 10/5 , 1960, that (I) (we) last saw the deceased alive on 10/5 , 1960, and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 1/16/60	
22c. PHYSICIAN'S NAME (Type) Dr. L. R. Schoolman		22d. ADDRESS 810 Toll House Ave.-Frederick- Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-7-1960	
23c. NAME OF CEMETERY OR CREMATORIAL Utica Cemetery		23d. LOCATION (City, town, or county) Utica Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE 		25a. ADDRESS N. Mkt. St. Frederick Md.	
25a. REC'D BY REGISTRAR Robert E. Dailey		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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2007.1

1940-1941

2007.1

garrison George S.

1940-1941

garrison George S.

1940-1941